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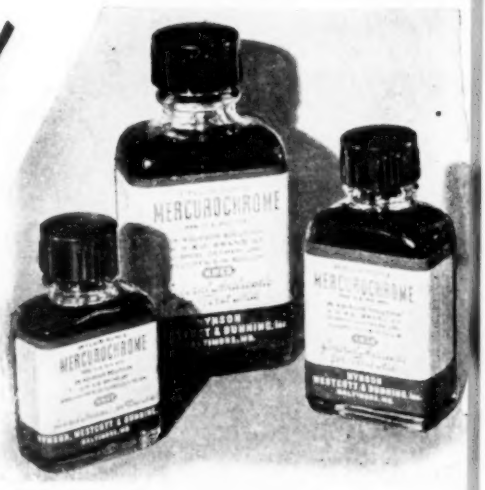

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PUBLIC HEALTH NURSING

Official Organ of the National Organization for Public Health Nursing, Inc.

Bringing You Up-to-date on the Proposed Draft

EVERY nurse in the country knows how urgently nurses are needed in the military services and the Veterans Administration. In April 1944 the Army upped its requirement from 40,000 to 50,000 nurses and since that time concerted effort has been made to raise the added 10,000. (An over-all ceiling of 60,000 nurses for the Army has recently been announced, and the Navy is seeking an additional 2,335 nurses.)

January 6—President Roosevelt reported to Congress:

"One of the most urgent immediate requirements of the armed forces is more nurses. . . . I urge that the Selective Service Act be amended to provide for the induction of nurses into the armed forces. The need is too pressing to await the outcome of further efforts at recruiting."

January 7—Katharine Densford, president of the American Nurses' Association, and Stella Goostray, chairman of the National Nursing Council for War Service, released public statements supporting the President's call for action and promising the united cooperation of the nursing profession in meeting military needs.

January 9—Representative May of Kentucky introduced HR 1284, proposing that registered nurses be subject to registration, selection, and induction into the military forces under an amended Selective Service Act. Any such registrant should be "assigned only to medical duties in which her professional skill and training will be used." The President would be authorized to prescribe regulations necessary to carry out provisions of the Act.

January 10—At a special meeting of the National Nursing Council for War Service in New York, the following was voted:

1. The National Nursing Council for War Service, in view of the growing national emergency, approves in principle federal selective service legislation for the procurement of nurses for the needs of the armed forces. (Note: This does not imply approval of any specific bill.)

2. In order to assure adequate nursing care to the civilian population, the National Nursing Council for War Service urges enactment of a national service act to supplement any selective service legislation for nurses.

Both motions were referred to the ANA for consideration and action, since the Council does not engage in legislative activities.

It should be noted that national service legislation deals with compulsory service by civilians in essential civilian jobs; that selective service drafts civilians to fill military needs.

January 9-15—ANA Committee on Federal Legislation, ANA Board and Advisory Council studied the situation. At a meeting in New York on January 15 the ANA Board took the following action:

"In view of the emergency declared by the President, the American Nurses' Association endorses the principle of a draft of nurses as a first step to Selective Service for all women. The Board also endorses the enactment of a National Service Act as recommended by the President to Congress.

The Board also goes on record as offering its services to Representative May, chairman of the House Military Affairs Committee, in drafting effective legislation and votes to do everything in its power to continue to accelerate the prompt and voluntary recruitment of nurses to meet the present emergency."

ANA Advisory Council voted *unanimously* to "endorse the action taken by the Board." (See *American Journal of Nursing*, February 1944.)

January 23—Surgeon General Kirk authorized the commanding generals of all the Service Commands to accept nurses who volunteer and meet Army standards without availability clearance from Procurement and Assignment Service. The commanding general may "determine if the volunteer is more essential in her civilian capacity before appointment." He may call upon P and AS as consultants on matters of availability for military service and essentiality to civil life.

January 23—The NNCWS, after pointing out that the Procurement and Assignment Service was formed to meet a need following indiscriminate enlisting during the first war years and that its machinery is now actively functioning in 900 communities, passed the following resolutions:

1. That the National Nursing Council for

War Service urge the War Manpower Commission to maintain and strengthen Procurement and Assignment Service for nurses as an agency cooperating with the Red Cross, Army and Navy and as the surest method of securing the nurses needed by the armed forces, and at the same time of stabilizing essential nursing in hospitals, schools of nursing and civilian health agencies on a basis of minimum wartime standards.

2. That the National Nursing Council for War Service urge the War Manpower Commission to conduct a mandatory registration of all graduate nurses at earliest possible moment.

January 24—Council resolutions sent to Paul V. McNutt, War Manpower Commission, emphasizing continued need for P and AS work, despite Army's declared policy (January 23).

January 24—Central Office (Washington) P and AS directed state chairmen for nurses to maintain present programming and planning; to do their utmost to protect absolutely essential nurses by notifying central office of such nurses being processed for commissions.

January 26—Stella Goostray, chairman, NNCWS, by letter asked state and local P and AS committees to render consultant service expected by General Kirk wisely and efficiently. She stated that the Council considered P and AS work still essential and asked that classifying and reclassifying continue as requested by the Central Office in order to "enlarge the pool of availables for military service."

January 26—Representative Edith Nourse Rogers of Massachusetts introduced HR 1666 providing for a draft of qualified graduate nurses and their commissioning in the Army or Navy. The President is to set up administration of the act.

January 26—The Board of the NOPHN discussed the three types of legislation possible (1) an amendment to the Selective Service Act of 1940 to allow induction of all women as needed for military service (2) amendment of the Selective Service Act to allow induction of nurses for military service (3) a National Service Act to make it compulsory for all civilians to do essential work. After pointing out the dangers of class legislation the Board passed the resolution on the nurses draft as published in this issue (p. 60).

February 6—Hearings began on the May bill before the House Military Affairs Committee. Surgeon General Thomas Parran, USPHS, gave the first testimony. Of particular interest to public health nurses were these words:

"If nurses were to be removed or were to desert suddenly from key posts, our entire nurse structure would collapse. . . . There are two groups of nurses where great damage may be done. Public health departments and visiting nurse associations employ approximately 21,000 nurses. None of them are overstaffed. In fact, this figure represents 20 to 30 percent vacancies. Public health nurses constitute the largest single group among all health department employees. Without nurses health departments cannot operate. Because many hospitals are overloaded, many sick patients are being cared for in their homes by visiting nurses. . . .

As the war progresses, the major civilian health problems are still ahead of us. We shall see the cumulative effects of fatigue, long hours of work, worry, anxiety, and grief. In other words, there is bound to be a lower level of civilian health and greater susceptibility to disease. We have been fortunate up to now in not having had any serious epidemics. It is well within the realm of possibility that we may have a repetition of the 1918 influenza pandemic before this war is over. If this or any other disaster were to occur, there would be no time to pass a law which would mobilize nurse powers where needed. . . .

The Public Health Service is concerned with any situation which threatens the national health. We must face the fact that even if current military quotas were filled by selective service, there still would be no effective military control over remaining nursepower of the country. . . .

It is for these reasons that I recommend a selective service principle for professional nurses to include minimum civilian as well as total military needs. This is total war. We must mobilize fully to guard against collapse on any front, military or civilian."

Hortense Hilbert represented the NOPHN at the hearings and filed a statement concerning civilian needs for public health nursing service.

February 7-8—Hearings continue with testimony from the Navy, American Hospital Association, Red Cross Nursing Service, and War Manpower Commission.

February 9—Katharine J. Densford, president, American Nurses Association, declared the willingness of the profession to use every resource to help provide adequate nursing care for men in military service, emphasizing also professional nursing responsibility for the civilian population. She stated the ANA believes the problem now presented can be dealt with by some federal agency with adequate authority, personnel and funds, and a federally financed recruitment program comparable in scope to the WACS and WAVES recruitment programs. The draft is a second alternative, but the ANA would accept this only as a first step in a Selective Service Act for all women. This should be further supplemented by a General Service Act. Minimum provisions in case of a draft law were outlined.

Civilian Health Must Be Safeguarded

THE Procurement and Assignment Service for Nurses of the War Manpower Commission was organized with the hope that nurses, employers of nurses, physicians and the public would voluntarily cooperate by taking appropriate action to effectuate the classification of nurses and to follow the standards suggested for civilian nursing services. These standards were based upon the minimum nursing considered safe for community and hospital, and represent service of such critical importance that it must be maintained. These standards were evolved with full recognition of the priority importance of providing nursing service for the men in the armed forces. The objective is to distribute nurses according to these standards to give the service they are best qualified to perform.

It may not be too late even now to prove that a sufficient volume of voluntary response to the suggestions of Procurement and Assignment can be attained. The problem is not one of competition—military versus civilian needs—because there are known to be enough nurses in this country to serve both military and home fronts. If the urgent appeal which is now being made by the nursing profession and all groups concerned should fail, then the only alternative is the proposal to draft nurses for military needs with its essential supplementary proposal for a National Selective Service for all men and women.

As Commissioner of Health of New York State, I feel it is imperative to reaffirm my conviction that the standard of one general public health nurse for approximately 5,000 population is a minimum which must be maintained. This standard was endorsed by the Procurement and Assignment Service as a guide to determine the essentiality of a public health nursing position. Where such service is not now available effort must be continued to promote public understanding and support for this goal. As part of this problem of providing minimum public health nursing service, nurses qualified for public health must be available for replacements and to approximate the number needed to fill new positions until the minimum coverage is reached in every community of the State. The fact that even this amount of public health nursing has never been reached in many counties is no excuse for daring to relax our effort to secure it.

I would like to assure every public health nurse of this state that her services are of the utmost importance. Each one working in a small community may feel at times that she could be spared. Each day's work when viewed by itself may not appear to be of vital importance to the war; but it is the work of public health nurses day by day which has contributed to the health of the people of this state. Every person kept on his job is of vital importance to the progress of the war. Freedom from sickness and protection of the community from epidemics do not just happen. Good individual and community health are obtained by the development of planned and purposeful programs which must be consistently performed.

The work which civilians must do as their share in the war effort is dependent upon the best health record which any community can be helped to obtain. Each immunizaton against smallpox and diphtheria totals to enough protection so that there has been no major outbreak from those diseases which would disrupt industry and cause added home responsibilities. Every tuberculosis case hospitalized and every early case found is important in the total program of tuberculosis control. Every syphilis case followed and kept under treatment is an important factor in the total program of syphilis control. As public health officials, our work in these fields must be intensified. Every soldier's wife and infant given nursing care under the EMIC program is an important service to the soldier whose morale is thereby helped. These and

many other services are rendered day by day by public health nurses. Their value cannot be underestimated nor their volume curtailed.

To those nurses and other workers in the health field who have been classified as essential by the Procurement and Assignment Service and who otherwise would be enlisting for military service, I would assure you of my understanding of the conflict which you are facing. You have chosen to prepare for the field of public health nursing. Your number is limited as compared to the total group of nurses who by virtue of their professional education alone are qualified for military duty. Let me repeat, there is no conflict between the two types of service; each is war work in its own sphere of effort.

Every opportunity should be utilized to inform the public and to persuade nurses and all allied groups to follow the leadership of the Procurement and Assignment Service which is the cooperative effort of the profession and the government to maintain both military and civilian services in proper balance.

Public health nursing agencies have been asked to do their utmost to conserve professional nursing personnel by reviewing programs and methods and by using supplementary service including volunteers. If all the proposals to stretch professional service have not been followed to the greatest extent, I would urge that this be done. If each of us makes every effort to understand the principles and problems of Procurement and Assignment and to discipline ourselves to render cooperation according to the service we can best perform, then each will have done his or her share during this critical period.

EDWARD S. GODFREY, JR., M.D.
COMMISSIONER, NEW YORK
STATE DEPARTMENT OF HEALTH

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NOPHN Resolution on Nurses' Draft

AT the Annual Meeting of the Board of Directors on January 26, 1945, the following action was taken:

The Board of Directors of the National Organization for Public Health Nursing endorses in principle an amendment to the Selective Training and Service Act of 1940 to include registration and selection of all women who may be needed for the military.

In proportion to its numbers, the nursing profession has responded on a voluntary basis more generally than any other group of women, nearly one third of the total number of active graduate nurses having applied for service with the Armed Forces. However, because of the urgent need for nursing service on both military and civilian fronts, and because of the length of time required for professional training, special action with regard to the selection of nurses may be needed as a preliminary step toward drafting women if the course of the war requires it, and recruitment of nurses on a voluntary basis does not meet the need.

The Board of Directors also expresses its belief that the Procurement and Assignment Service of the War Manpower Commission should be maintained and strengthened at this time, and that its classification be used as a guide to the selection of nurses.

The National Organization for Public Health Nursing re-emphasizes the importance of maintaining a minimum of essential public health nursing service for the protection of local communities and suggests that all public health nursing agencies and nurses abide by the Procurement and Assignment classification.

Psychosomatic Viewpoint in Public Health Nursing

By RUTH GILBERT

IN RECENT years we have been able to bring ourselves to a broad concept of what can be called the psychiatric point of view and have made progress in relating this to our work as public health nurses. We did not always have this broad point of view both because the field of psychiatry and mental hygiene was, naturally, much less developed, and because we as nurses had not yet had time or experience to grasp the ways in which this point of view and body of information could be integrated into our nursing work. Until recent years psychiatrists were primarily interested in precise diagnoses. Also we were all spending a great deal of time—and probably having to spend it—with the help of the allied field of psychology, in recognizing and dealing with the more seriously mentally defective, that is, the feeble-minded or worse. In addition, in those days a great many people thought that "mental hygiene" consisted of a body of rules which could be learned, followed, and passed on to others who would then also follow them. The world was expected shortly to become a happier, more smoothly running place—at least in the eyes of those to whom these "rules" seemed good.

We gradually learned better. As the result of a lot of investigation and treatment experience it became apparent that in spite of individual differences, human beings, sick or well, are much alike under the skin with no sharp dividing line between the "maladjusted" and the "adjusted." We began to realize that those terms are to some extent sociological because the place and particular group in which an individual lives sets the standards for his behavior. We learned also that people's behavior is not based on conscious, reasonable motives but is based in large part on unconscious motives, some of which can be clarified and understood by the individual himself and by others. We learned that diagnostic categories are not always precise or even of leading importance. The public health nurse has learned that her tie-up with psychiatry is not alone for the purpose of recognizing major mental illness or intellectual inadequacy in her patients and securing appropriate help for these, though this continues to be important. She has learned that psychiatry can be of most help to her through aiding her to understand the feelings and resulting behavior of individuals, and therefore of families, so that she can guage her work in these families, understanding better the differing needs of all these people and the methods of work which will be most helpful to each of them. Furthermore, the public health nurse has learned to understand and use her own feelings and emotional reactions more accurately, and how to manage herself in relation to her patients. As illustration we can cite again the nurse's developing understanding of the so-called dependency relationship between herself and her patient. Years ago we were apt to foster such a relationship unthinkingly from a desire to "get things done" and to relieve symptoms of ill health as quickly as possible. When the evils of this were pointed out, we shied away from all dependency relationships with our patients. Now we are learning to individualize and to foster self-help when the patient is able to achieve this, but to accept dependency upon us on the part of the inadequate individual who

needs a dependency relationship temporarily or perhaps permanently.

Interestingly enough, we have learned our lesson sufficiently well through these years so that now we can begin to differentiate again between certain concepts and certain fields of work from the psychiatric point of view without losing sight of the whole field of human behavior. Some of these special aspects within this larger field especially interesting to nurses are, for example, the field of child development; at the other extreme, the better understanding of the aged. Psychiatry by itself is not responsible for this entire development. Increasingly psychiatry, psychology, physiology, sociology are making use of each other's findings and in many ways growing closer together.

ANOTHER example of a special emphasis within this broad framework is the topic of this present discussion, namely, psychosomatic relationships. We are considering the intimate tie-up of people's feelings—their emotions—with bodily symptoms and the balance of these two sets of factors. This is something in which public health nurses are interested whether they include a "morbidity service" in their program which means that they spend considerable time in bedside nursing, or whether most of their time on duty is spent in direct health teaching with those presumably not ill.

The reason for the interest of those who do bedside nursing is obvious since they inevitably will find patients whose emotional difficulties are finding expression in bodily symptoms.

Nurses who are not doing a bedside program also find an understanding of psychosomatic relationships helpful—better to say necessary. There is an immense group of the chronically ill. It is our job to help to interrupt this illness, when possible, before it has reached chronicity. I think we might say that there is a still larger group of individuals in our population of which the chronically ill individuals might be considered as the core. These are the people who have a smaller measure of general good health and well being than could be the case but whose condition is not sufficiently acute to bring them to the attention of a physician except perhaps sporadically and who rarely have consistent help in their difficulties. In this army of people are many individuals whose emotional problems are bearing poor fruit in the form of a minor degree of somatic symptoms but still a degree sufficient to keep them "ailing."

Children may well belong in this group but for the moment it is adults whom I have in mind. The picture which rises most clearly to my mind is that of a mother with a number of children in one set or another of difficult circumstances, never really sick, but never really well. She does her work with difficulty; she has no joy in it and little in her family; and she has one or another or a series of somatic symptoms which never can be quite pinned down. It is possible that this woman may belong to this "ailing" group.

In the September 1944 issue of PUBLIC HEALTH NURSING Magazine appears a rewrite of an article, *Highlight and Shadow*, published in the Maternity Center Association's *Briefs*. The article described the successes we have had in cutting down the maternal mortality rate. It goes on to say that a number of forces are at work which still militate against the safety of mothers and newborn babies.

> Many a mother is dragging through life with a tired, under par, unwilling body. Her contribution to her home, to the care of her children is at low ebb. She is able to do the necessary things but life may be a burden. The tragedy is that so many of these miseries and ailments are preventable and curable. It is only when a physical or mental breakdown occurs . . . that the usual health facilities of the community are marshalled to protect these women. Notwithstanding much big talk about the importance of preventive care—the bulk of community health service is really emergency sickness service. If we accept the concept of positive health—the best possible health for everyone—then communities must recognize more fully the importance of preventing, discovering early and treating disease.

TIME was, some years back, when many public health nursing organizations initiated a program of "adult health supervision." This program never has seemed to me to go very well, although naturally I say this with some hesitation.

One reason for this may have been that we became increasingly involved in our programs for children about whose care there was an ever-growing and really helpful body of information for our use. However, the lack of success of many of these programs was not entirely that our attention was drawn elsewhere. Our attention could not have been diverted if we had had more understanding of ways in which we could be helpful to adults.

Our knowledge of the health needs of adults is increasing, however. Probably the widest gateway by which public health nurses are again and with greater understanding entering the field of adult health education is industrial nursing which of course has been augmented tremendously during the war. We realize that the health or illness of industrial employees often is not only a matter of individuals but relates also to the well being of their families. Many of these adult employees are parents of children. Since we know that the illness of adults who form the emotional environment of children is very significant in the development of the child, we see again that whether or not our special interest as public health nurses has seemed to emphasize work with children, our work with adults is an essential part of our program. We need, then, to work as accurately and as thoroughly as we can with the great group of "ailing" adults, some of whom undoubtedly are showing psychosomatic symptoms in the sense described.

WHAT can we do for them? How much can the public health nurse be expected to grasp and use of the theory of psychosomatic medicine? Is this a time-consuming method of working which may also add to our already large case loads?

First, we can say—and with some thankfulness—that the ultimate diagnosis is not ours to make. This is the job of the physician. It is not an easy job, and much work remains to be done in the field of psychosomatic medicine.

We can, however, take the definite step, if we have not already done so, of accepting without reservation that this specific relationship between the emotional and the physical or physiological exists, and acquaint ourselves with the commoner patterns of this expression of difficulty. If we do so accept and add to our information it means that we are able to shed any clinging shreds of scorn or perhaps merely of impatience with the individual whose source of difficulty may lie as much in his own feelings as in the virus he has acquired from outside himself. We understand better when we remember our own "nervous indigestion" or similar physiological symptoms when we have been confronted with a situation which alarms us.

Second, I want to point out and emphasize that we can still further sharpen up our powers of trained observation of our patients.

It can be said first, that nurses in general do a good job in their observation of patients. We as a group are rather dutiful people, prone to spend considerable time and effort in getting rid of our possible deficiencies. Our powers of observation are, on the other hand, one of our assets, and we can take pride in this and use it further. We are trained from the outset to observe the somatic symptoms of the patient precisely, and the better nurse we are, the more accurately and fully do we note those symptoms. Public health nurses in addition to noting such signs and symptoms are trained and experienced in observing the patient's *way of life*. The phrase, "way of life," conveniently covers a big field. Examples of what we observe here are, type of employment, wages, reactions to employment; type of home, standards of housekeeping, standards of home-making (a very different thing); family relations including the recognizable capabilities and inadequacies of the various members of the family, the way they get on together, the way the children are trained, nurtured and are, or are not given security; the goals an individual or a family may have, the peaks which he or the family as a whole has reached or the slumps into which they have fallen; and, as time goes on, something of the background of the individual. It is no mere manner of speaking to say that the nurse perhaps more than any other professional person

acquires an intimate contact with the family which enables her to have much of this information. In some instances when her services are not desired, she does not acquire this information easily or perhaps at all. Also, when a public health nurse serves a very large rural area she cannot have the intimate personal contacts which develop between the nurse in an urban district and her patient. Nevertheless basically it is true that the nurse knows or can know her patient's way of life.

To state what I have just said more precisely, the nurse has carried over in her public health nursing work her skill in observation of the patient's somatic symptoms to some degree of skill in observing three things: first, the patient's circumstances; second, the patient's own characteristic adequacies and inadequacies; and third—a combination of the other two—the patient's characteristic reactions and behavior.

This fits into our subject of psychosomatic relationships in the following way. All living might be described as a surmounting of obstacles. A successfully surmounted obstacle means that we have been big enough to "get over it." This depends on how big the individual is relative to the obstacle. The circumstances which surround the individual, some of these of course of his own creating, are his particular obstacle. Of these circumstances the nurse is able to observe a great deal that is of importance in understanding the reactions of the patient.

You have, of course, often watched a baby just able to walk as he approaches some ponderous object in his path, perhaps a big chair, which he cannot climb over in his present state of development; nor is he yet capable of knowing that he can move around the chair. He cries in angry frustration. So with the adult patient of whom we have been speaking. He is living along with the obstacle—not as clearly defined and obvious as the chair—which he does not know how or is not able to surmount. His response may be somatic symptoms since as a socially disciplined person he may repress the emotional explosion of the infant. Our point is, that to a considerable extent the nurse can observe both the patient and his difficult circumstances as she did the baby and the chair which blocked his progress.

I WANT to make briefly five points about the way in which these observations can be carried out if they are to be skilled, helpful ones.

In the first place, the nurse's study of the circumstances of an individual or family is best done as a series as far as this is possible. Even if one returns to the same family only infrequently, one can seek to reinforce one's knowledge of the same points previously observed. We may see on the occasion of one visit that a mother is embroiled in incompleted housework with the familiar picture of confusion present and with irritation apparent in her handling of small children. If we often find her with vague complaints of "stomach trouble," headache, or backache, for which she does not consult a physician, is this then true on our next visit? Is it different in any degree and precisely how is it different? We may find that the circumstances we saw on the occasion of the first visit are characteristic; we may find that those circumstances were the exception. Repeated observation of the same facets of family life, if we are in a position to make them, give us a true picture. Naturally we do this, all of us, to a certain extent. But we could carry this out more consistently and purposefully.

A second point is allied to the above. There is great value in observation of an individual or family at other times than during crises. True, an individual handles a crisis in the way in which his whole life has prepared him to do this. But we know, for example, that many neurotic individuals may rise to great courage and effectiveness at a time of extreme danger or difficulty whereas that same individual when confronted with the daily smaller difficulties of living may be a burden to himself and others.

Third, a nurse cannot make accurate observations if she is at the time emotionally aroused herself. I remember a

very good public health nurse who came into a home just after a small baby had fallen from his bed, and found the mother absent. She was frightened and angry at the apparent neglect of the baby. Her impression of the total situation she later found was not entirely just and her relationship with the mother suffered because of what she said under stress of her own feelings when the mother returned.

Furthermore, a fourth point, we can never forget that our observations may be colored by our own standards of individual behavior or family life and so may be inappropriate to the situation observed and therefore an inaccurate basis for helping that individual. Perhaps this can well be briefly pointed up by the old couplet,

> "I beat her; she beats me—
> We love each other tenderly."

A fifth point relative to the observation of the patient's way of life has to do with the specific accuracy of our observation, and also with our recording of this. Let me give you an example of what I mean.

The nurse writes on her record regarding a home visit made to a child with an upper respiratory infection. TPR are indicated in the usual place on the record form. For the running record the nurse writes:

> Patient being kept in bed. General care and throat irrigation given and mother instructed in these. Apartment dirty, dishes unwashed, mother seemed tired and disheveled. Return visit in two days.

You will agree with me that the nurse missed a trick there. Either she did not observe accurately, or failing to realize the importance of this observation in understanding the situation and planning, did not sort out her impressions clearly. Because, on further discussion with the nurse who made this visit—and it was a "good" visit—one finds that the observation actually was as follows:

> Patient being kept in bed. General care and throat irrigation given and mother instructed in these. She handles equipment well, child reacts well to her. Three-room apartment dirty, windows unwashed, corners not dug out and clothing stacked on chairs. Remains of breakfast are doughnuts and coffee. Mother looks thin, posture and color bad, hair dry, lacks upper dentures. Housedress torn as well as dirty. Mother said, "I never get anything done." Return visit in two days.

In describing these five essential considerations on our observations of patients I do not think we have strayed from the subject of psychosomatic medicine in relation to nursing. We have been saying that since somatic symptoms on an emotional basis are the result of an individual's unsuccessful struggle with his circumstances, the nurse must put her best powers of observation to work on both the individual and the circumstances.

ALL RIGHT—now we have this careful, accurate information as the result of our observation. What are we to do with it?

Some of this material should be brought to the physician speedily and in as much detail as he will accept. How else is he to gain knowledge of it in many instances?

But this is also true. We shall have found that the process of observation and the process of treatment are not two separate things. The nurse finds that as she understands the situation better, at that time she and the family find ways of improving it, some a great deal, some a little. This is a cumulative and dynamic process which except in very difficult cases results in some progress if the nurse is resourceful. Often she need not rely solely on her own resourcefulness but can call on other community agencies when this is appropriate and when such agencies exist.

Again—still speaking of how the nurse shall use the results of her observation—there is a ticklish point which we can raise as a question but which each public health nurse must think through for herself. How far can the nurse take the responsibility of de-emphasizing somatic symptoms when her knowledge of the total situation indicates that emphasis on the somatic symptom by referral of the patient for physical examination may imprint the pattern of physical illness more deeply? I am referring here to patients not already under the care of a physician, who belong to the "ailing" group de-

scribed. Let me give you briefly a case in point and you can decide for yourselves whether you think the nurse proceeded wisely.

A public health nurse was called into a home by a young mother who had heard that the nurse could give help in budgeting, especially in buying food for a balanced diet. This woman's husband had been in the armed forces four months. He had taken all responsibility for buying during the five years of the marriage. There were three children. The mother complained of dizzy spells. The nurse noted that this dizziness always occurred in connection with some budget problem. Well, a good many of us become a little dizzy when we confront the budget. Seriously, however, what is the nurse to do about this dizziness? Should she at once suggest physical check-up? There is no family physician in this instance. Dizziness began after the husband went into the Army. Further inquiry lead the nurse to feel that she would at least postpone suggestion for physical examination in order not to emphasize the somatic symptoms while at the same time attempting to give all the help she could give—and get—regarding the family circumstances.

Two questions frequently are raised—or felt, though not expressed—about this more analytical way of working. First, isn't it time-consuming? On the contrary, I think we may say with some assurance that it is time-saving. If you have a map, even though the map lacks some details, you get where you wish to go much more quickly than would be the case were you steering by more vaguely seen, though somewhat familiar, landmarks. In other words, precision gives our work direction and thus speeds it up. We make fewer unproductive, scattered visits when we are more keenly alive to the situation and what we are trying to do in it.

The second question often asked is, does not this mean that the nurse takes on extra work—makes more visits—before she has, as we still sometimes say, "corrected" the problem situation. This, too, can be answered in the negative. We need to remind ourselves that we are sometimes justly accused of being perfectionists. "Correction" is a relative matter, and has limits. Granted the limitations on the nurse's time and on the ability of the patient to improve, within these limitations we can put our time to the best possible use.

ONE CANNOT and probably should not tie off a discussion of adult health in these days without specific mention of the returning men and women of the armed forces and the adjustment problems which are now confronting us. It seems that for our purposes at the moment, we should not make a special category of these individuals. They *seem* to constitute a special category because their numbers are legion. Our degree of responsibility for these men and women depends somewhat on the stage of development of the area in which we work. Hopefully we need not assume the sole responsibility for solving or even steering problems of adjustment of men and women discharged from the armed forces. This is a community responsibility which is best assumed by coordinated community effort including business men, the legal profession, religious leaders, and others, as well as physicians and the group known as welfare agencies of which we are one part. If such coordinated community activity is not under weigh in our community, I think it is our responsibility to aid in getting this in motion. It is inevitable, however, that we shall come in contact with many discharged veterans, some of whom will need the services of the nurse. Basically their problem is no different from the situations we have been discussing. We shall need to observe them and their circumstances and the way they behave in these circumstances, in a manner no different than that described. True, their circumstances may often be unusual and poignant and related to war experience. But no two people have the same set of circumstances, be they civilians or members of the armed forces.

I want to turn now to one brief illustration of this same kind of situation in a different age group, namely, the school-age child. Having established to a certain extent some of the ways in which we as nurses are concerned with emotionally-based somatic symptoms, we can use an illustration at this point to bring more of our case load into this same focus.

The small boy I have in mind was referred to a child guidance clinic by the school nurse in the large city school which he had been at-

tending. He was ten and a half years old at the time of referral during the summer and expected to enter fifth grade in the fall. The nurse in referring this child said that in recent months he had developed a series of fears and anxieties in regard to going to school, then with regard to going to Sunday school, and finally was afraid to leave his home except in the company of his mother. Along with this he had physiological disturbances such as vomiting and diarrhea. When first seen by the psychiatrist he appeared rather small for his age, friendly but definitely tense and fidgety. He had a marked stammer. In response to a question he said that he liked school. He seemed to get on quite well with other children and had what might be called normal interests for a boy of his age in that he formerly did well at active games and wanted, when he grew up, to join the Navy and be on a PT boat. A series of interviews with this child and also psychological study were planned. The mother was much interested in having this done. She was worried about his fears and somatic symptoms but had few "complaints" to make about his behavior otherwise. He did quarrel excessively with his brothers and sisters. She was concerned, however, as to how to get him back to school this fall. Of this she said, "He will wait until the last minute and then go through what he did before—the nausea and diarrhea."

Psychological study showed this boy to be of adequate intelligence and ready for his fifth grade placement as far as school achievement was concerned. However, psychological study as well as interviews with the psychiatrist showed that this child seemed to feel misunderstood at home and dissatisfied with his abilities. He seemed afraid to stand on his own feet and still wanted to lean heavily on his mother.

The mother appeared at the clinic as tired and harried. Material from the school nurse's knowledge of the home brought the psychiatrist the information that she had for years managed her family of five children with the greatest difficulty; that she was over-precise in her housekeeping standards and was never able to live up to these; that her husband was working long hours and was nervous and irritable. The nurse had observed that the child had been somewhat lost in the shuffle in that, falling as he did in the middle of the group of children, he was neither baby nor older child. He had not been helped to take responsibility at home. In fact, as a supposedly somewhat sickly child, he had been protected from small household tasks. Yet his fumbling attempts to stay on as a baby were not well received by his parents. He had always been a child whose stomach yielded up easily. Afraid and not ready to stand on his own feet, with the vomiting already "natural" to him, his pattern of somatic symptoms under pressure of new situations was readily established. His stammering was also seen to be of emotional origin. Interpretation to the family and to the school and the successful meeting of the new situation at the clinic by this child over a period of time, gave him enough added security so that now he is able to take his hand out of his mother's. At the present time he is doing quite well in school and is not showing the symptoms for which he was referred to the clinic.

Carrying this discussion one step further in the chronological age groups, I would like to give you in closing one further illustration which has to do with an infant.

During the past summer a nurse went to a home in her semi-rural district used as a foster home by a state child-placing agency. The foster mother in this home was a warm-hearted woman who had an imposing record of good care of infants who needed special care and "building up." A new foster child had come to this home since the nurse's last visit. She was shocked when she looked at the baby. He was five months old and resembled a newborn in size. His color was bad and he was emaciated and dehydrated. His movements were feeble. This child had come to the foster home from an institution where he had spent the five months of his life—an institution which had tried its utmost to bring this baby along to growth and vigor. Repeated physical examinations revealed nothing specifically wrong with this infant as a basis for his condition. There was no particular lack of tolerance of the formula on which he had been placed and which was still the ordered feeding in the foster home.

The nurse returned to this home five weeks later after an absence when another nurse was in touch with the home. She did not recognize the baby. He was filled out, rosy, active. Here we undoubtedly have an example of a baby who was dying, whose somatic symptoms were due to emotional starvation in a baby who could not cope with that deprivation. The foster mother had not changed the baby's routine, but she had obviously administered the routine as a mother to her child.

I give you this illustration, not because the nurse herself had a hand in working through this problem, but because it shows as clearly as any illustrative material I know, the tie-up between the somatic and the psychic in this age group. When we have constantly in mind that the reactions of the adults we have been discussing stem in large part from the kind of nurturing and training experiences they have had as infants, we realize what an important job the nurse has in this connection. Probably you have read Dr. Margaret Ribble's *The Rights of Infants* which develops this material in relation to the newborn and infants in a highly specific way, and which is fresh and necessary material for every nurse.

IN BRIEF SUMMARY—we have been discussing psychosomatic medicine as it relates to public health nursing in the following manner. We recognize this as the tie-up between the physiological and the emotional. Often we see the somatic symptoms first. As nurses we can benefit our patients by observing not only the somatic symptoms but the circumstances of the patient and family, and their reactions on the basis of their own adequacy or inadequacy. This approach may be especially useful in working with the immense number of "ailing" adults who usually do not have consistent help. We can sharpen our observation of these patients. This process stimulates and directs our concurrent work with patients, and reporting of our observations aids the physician. This approach is applicable to all our work. It is not an additional demand upon our time. On the contrary, it can be a tremendous time-saver but it does call upon our skill, our resourcefulness, and our background of information.

NJOPHN Participates in Health Council Program

Digests of certain health studies and actions undertaken by some dozen lay groups in the state of New Jersey, including the Lay Section, New Jersey Organization for Public Health Nursing, are contained in an interim report recently issued by the Citizen Health Council of New Jersey, of whose Executive Committee Mrs. Walter G. Farr, director, Lay Section, New Jersey SOPHN, is chairman.

The Council, which was organized in June 1944, is composed of representatives from state lay organizations that have public health programs and members at large who are citizens with broad knowledge and experience in the field of public health. It seeks to interchange and interpret health information and problems, working toward a broader understanding and greater synchronization of action by lay organizations concerning such problems in the state.

State department of health changes, and problems relating to industrial health, dental health, and medical care constitute the primary fields so far studied. Some specific problems reviewed in the Digest are: suggested merger of the health and welfare departments; reorganization of the New Jersey State Department of Health and recommendations embodied in the USPHS survey of the Department (Williams' Report) including recommendation of the establishment of a Bureau of Public Health Nursing; greater coverage for compensable diseases; relationship between state departments dealing with industrial health; raising and amplifying present required standards for workroom conditions; improved facilities for more widespread institutional medical care without discrimination as to color; wider distribution of medical care.

Committees of the member organizations made studies and came to conclusions by (1) arranging panel discussions by professionals (2) inviting qualified speakers and discussants to meetings (3) studying and reporting on books by recognized authorities in the field of public health (4) pooling knowledge of the various committees' members, experienced in community or state health situations.

In the Foreword the Council points out the value of joint study and action by groups of diversified interests and experience, "for a proper evaluation of proposed and existing health programs, of proposed and existing health legislation is dependent on learning all the facts . . . Those assuming responsibility for guiding the health thinking of their organizations will welcome, we believe, the opportunity offered by this Council."

Preparation to Meet Psychosomatic Problems

By MARY C. CONNOR, R.N.

THE question presented by an increasing number of nurses during the past year, namely, "How can I prepare for the position of mental hygiene consultant?" has brought forcibly to our attention the dearth of public health nurses so prepared. In view of this we have been asking ourselves, "Who is to help the supervisors and staff nurses on the job if we are to make the contribution in mental hygiene which we believe we can and should?" While recognizing that the war has accentuated mental hygiene problems, we know that these problems have always been with us, although fewer in number and less striking in character. Through its violent disruption, war forces us, as only a war can, to a new perspective, and thereby brings issues into clearer focus. As a profession we are "coming of age" and must now make plans for our future growth. In this, the role of experts is vital if we are to continue to grow.

For practical purposes in this discussion, let us first consider the public health nurses who are now on the job. It is obvious that in carrying out their functions they are inevitably confronted with the mental hygiene needs of their patients. The public health nurse encounters these needs at every turn, and anything that can be done to strengthen and improve what she is doing is a gain.

Her role as the generalized health worker is comparable to that of the internist in medicine, as described by Dr. Louis Hamman of Baltimore in a paper entitled, "The Relation of Psychiatry to Internal Medicine:"[1]

> To the specialist, psychiatry is another specialty operating in a contiguous but separate domain. To the internist, it is a vital and integral part of his work. Indeed I find it impossible to formulate a clear expression of the relation of psychiatry to medicine, so intimately and inextricably are they bound together. The physician studies and practices psychiatry continuously, even when he protests that he has not the least knowledge of formal psychiatry. It is the chief instrument of his success, even though he may practice it unconsciously. . . .

Realizing the truth of this statement, we believe it important that the nurse be conscious of her contribution and its possibilities of growth.

Two channels are already in use through which we may help the staff nurse—through formal education in the university, and through in-service education. According to the U. S. Public Health Service[2] figures, as of January, 1944, there were 19,821 public health nurses, exclusive of industrial nurses, employed in the United States, the Territories of Hawaii and Alaska, Puerto Rico, and the Virgin Islands. This total does not include figures for New Jersey. Of the 19,042 for whom qualifications were received, 5,564, or 29.2 percent, had completed one or more years in a university offering an approved program of study in public health nursing. This percentage represents a minimum figure, since it is exclusive of those nurses who have completed part of the program and others who have a baccalaureate degree on admission to the university.

UNIVERSITY PREPARATION

By an "approved program of study in public health nursing" is meant the professional content recommended as the special preparation for public health nursing and approved by the National Organization for Public Health Nursing.

Thirty universities, located in 20 states, in various sections of the country, offer such programs; 21 of these 30 offer a course in mental hygiene carrying from one to three semester hours' credit; 8 of the 21 also offer a course in child development carrying from one to three semester hours' credit. One other university offers a course in child development. A course in psychology (considered by some as introductory to mental hygiene) is required in the program of study by 21 of the 30. In some of the remaining 9 universities in which these courses are not required, students on admission have already completed them.

It is probably unnecessary to warn against drawing unwarranted conclusions from the foregoing data which are based on titles of courses. As most of us know from personal experience, either as former students or faculty members, or both, "things are not always what they seem" in the realm of titles in educational bulletins. They can be very misleading, especially in this field of mental hygiene. The course that is labeled "Mental Hygiene" may not be the one in which the student gets what we as public health nursing educators believe she needs. In fact, it is sometimes startling to find where she does get it. With this qualifying admission in mind, aware that a new day may be dawning when courses will not be set up on the basis of "minds" or "bodies" or in terms of the particular profession interested and prepared at the moment for purposes of this discussion we may say that a minimum of 29.2 percent of the public health nurses are likely to have had courses in psychology, mental hygiene, and child development. In regard to the total program of study, we have no facts on how the principles of mental hygiene are integrated and applied. This is much more important, many believe, than whether a separate course is offered, because mental hygiene is one of the strands through which an integrated program is achieved.

IN-SERVICE EDUCATION

What of the preparation of the remaining 70.8 percent who had had less than a complete program of study or no formal postgraduate professional education? Both for this group and the group who have had formal preparation, staff education programs in mental hygiene should be planned. A considerable number of public health nursing agencies have developed such programs and, in addition to the psychiatrist, have drawn heavily on the services of the psychiatric social worker either on a full- or part-time basis. Methods for staff education programs have to be worked out locally, and it is evident from current practice that we are growing in our appreciation of the case study or family study conference or seminar method. Reference is here made to the planned discussion of the total needs of a particular patient in relation to his family and the community of which he is a part, as well as the resources and limitations of the professional groups serving him. This conference method means relatively small groups and in a large agency will probably involve more time, but there is no question of its value in comparison with the lecture method. The conference, well planned and well conducted, is the quickest and most effective way to come to grips with a problem.

While deeply respecting the advantages of formal education, we agree with what Dean Gildersleeve of Barnard College said, "That great American superstition that the only way you can learn anything is having a course in it, has, of course, been a dreadful blight and handicap in our American education." We would do well to take heed of this warning from general education, since we are in a stage of development in which the patterns we set may be influenced unduly by this "blight."

In choosing specialists to assist us, we need to be discerning about their approach. Too long our thoughts have been directed to the physical illness of the patient on the one hand, and to the mental ills on the other, as though they were separate and distinct. Psychosomatic medicine stresses the mental as one aspect of the functioning of the whole organism and the effects of mental and

emotional functions on the organs of the body, as well as the effects of disordered organs on the function of the human being as a whole. The work of the nurse as well as that of the doctor must be transformed to be in accord with this concept. She needs to have an appreciation of how illness affects behavior and vice versa, and the part which she herself plays in the nurse-patient relationship. Too often she is not aware that she is a factor in the situation and thereby fails to make conscious use of herself as a resource. The nurse needs to understand human nature and must be interested in her own growth in this understanding.

BASIC PREPARATION

No discussion of the preparation of the public health nurse is complete without reference to her basic education in nursing as a whole and in relation to the specific part of it devoted to psychiatry. In regard to the former while much still remains to be done, steady progress has been made for the past thirty years, if the following may be taken as evidence—growth in professional self government, studies and surveys of nursing service, strengthening of curricula and raising of other educational standards, establishment of schools and departments of nursing in colleges and universities, and closer relationships with other educational groups. The largest single problem affecting the vast majority of the 1,297 schools is the economic dependence of the school on the hospital, with the result that student nurses still furnish all or a large part of the nursing service of the hospital. Closely related to this is the fact that while, as a profession, we subscribe to a democratic philosophy, we do not apply it in the education of the nurse. This is partly due to our traditional heritage from clerical, military, and medical influences, but also inescapably to the fact that the hospital is an institution where the doctor has to assume an authoritarian approach in the patient's own interests, where life and death are in the hands of the personnel, and therefore, strict discipline in certain matters must be observed. However, this is equally true of all groups working within the institution and not only of nurses.

Isabel Stewart, one of our outstanding leaders, in her recent book, *The Education of Nurses,** points out that one of the important problems facing the profession is in this realm of philosophy. She states:

> Nursing educators who are concerned with formulating a democratic philosophy of education must be able to evaluate, balance, and integrate all these different ideas and methods. They will have to give due weight to individual development and at the same time provide for the general well-being; to harmonize interest and effort, freedom and duty, theory and practice, independent thinking and respect for authority. Nursing schools must consider how they can provide for both technical training and liberal education, how they can insure proper preparation of the professional nurse without sacrificing the woman and the citizen, how they can safeguard the personality of each individual and at the same time provide for necessary discipline and efficiency to meet the crises of life and death. . . . One of the first steps toward improvement seems to be a reconstruction of the philosophy of nursing education to make it more consistent within itself and to bring it into harmony with accepted democratic principles and with modern methods of education. The effort to preserve the best in the nursing heritage and combine this with other elements needed in adjusting to modern life is one that will take much study and careful thinking.

The growth of collegiate and university schools of nursing is a most encouraging development, even though the number, estimated at about 140, is relatively small. In many of these, the pattern of nursing education has not been altered fundamentally, and academic and nursing education courses exist in various combinations and varying degrees of integration—all the way from a very slight affiliation between the university and the school of nursing, to the other extreme, in which the school is an integral part of the university and in which there is a thoroughgoing integration of academic and professional content. In the latter type of school conditions are most favorable for giving the students a sound foundation in mental hygiene.

PSYCHIATRIC NURSING

In regard to psychiatric nursing, in only one state and the District of Co-

lumbia do the state boards of nurse examiners require affiliation in psychiatric nursing. The reason most frequently given for not requiring it is that the personnel in psychiatric institutions is not prepared for the educational responsibility of students. On the other hand, the institutions (and this is also true of tuberculosis hospitals and sanatoria) either do not have the money to finance an educational program or are satisfied with the nursing care by the personnel classified as attendants.

According to the 1943 List of Schools of Nursing Meeting Minimum Requirements Set by Law in the Various States,[3] there are 1,297 schools in the country. Slightly more than half, or 54 percent, provide psychiatric nursing experience. This is an increase of 4 percent over 1939. In 31 percent of the 54 percent, it is given through affiliation, and in 18 percent it is given in the home hospital; in 1 percent it is given partly at home and partly through affiliation. Four percent of the schools reported that it is elective.[4]

The Nursing Committee of the American Psychiatric Association has been greatly concerned about the nursing care of patients in mental hospitals for several years, because the supply of adequately trained nurses appears to be decreasing, while the number of patients is increasing. For this reason, the committee requested assistance from the Rockefeller Foundation to study the situation. A grant was authorized and the work was begun July 1, 1942, by Laura Fitzsimmons. A progress report of the survey appears in the March 1944 issue of the *American Journal of Psychiatry*, and also in the August 1944, issue of the *American Journal of Nursing*. A few facts stated in these articles are mentioned here, since they relate to the subject in hand. During the last fifteen years there has been a tendency to discontinue schools of nursing in mental hospitals because it was believed that this type of hospital could function best as a laboratory for clinical experience for students from the schools of nursing connected with general hospitals, and in the field of postgraduate education. While this is true, Mrs. Fitzsimmons points out that these two sources do not furnish us as yet with an adequate supply of graduate nurses interested in mental nursing. The data reveal that, of the hospitals visited in the United States, only three had active postgraduate courses at the time, and that these three courses had a total enrollment of four.

In one state where there are no postgraduate courses in psychiatric nursing and only one graduate nurse who has had a course in psychiatric nursing, there is a state hospital with 1,049 patients. Data submitted by the state boards of nurse examiners in January 1944 showed 32 mental institutions conducting schools of nursing and 17 of these are located in New York State. When we consider that mental patients occupy more hospital beds than do all other hospital patients combined, and that only one state and the District of Columbia require psychiatric nursing experience for all student nurses, the great need for psychiatric nursing is apparent. The growth of knowledge in psychosomatic medicine and the impact of the war force us, since we believe an affiliation in psychiatric nursing is as essential as one in medical nursing, to assume our share of the responsibility, as public health nurses, to assist state boards of nurse examiners and state leagues in making the resources of psychiatric institutions available to nursing education.

ADVANCED PREPARATION

As it is not possible to discuss postgraduate education in public health nursing and ignore basic nursing education, so it is equally impossible to omit mention of the qualifications of those charged with this responsibility. As a profession, we are aware that we do not have a sufficient number of experts prepared to meet present demands. This is due to the fact that as a young profession, not yet one hundred years old, we have been occupied with problems of the education of the nurse as a practitioner. First things must come first and this is the first period of growth in any profession. We are

emerging from it and the time is due to prepare specialists in the clinical fields, in administration, supervision, teaching, and research. With this in mind, the National League of Nursing Education appointed a Committee To Study Postgraduate Clinical Nursing Courses in July 1943, with representation from the various nursing groups, including public health nursing. In the June and July 1944 issues of the *American Journal of Nursing*, the committee gives a progress report of its work during the past year. It has drawn up basic principles which underlie advanced nursing education, and, through a subcommittee, has outlined an advanced course in psychiatric nursing. It is hoped that the work of these two committees will give impetus to the development of advanced courses where university and clinical resources are adequate.

Three universities have already worked out advanced programs of study in psychiatric nursing. In several other universities where programs of study in public health nursing and psychiatric social work exist, the representatives of these two professions have been exploring the possibility of developing a program of study to prepare the public health nurse as a mental hygiene consultant, through a pooling of the university resources in both fields. We believe that the advanced preparation of the specialist in psychiatric nursing whose work lies in the hospital field, and the preparation of the mental hygiene consultant in public health nursing, is the same up to a certain point—that is, there is a common core of knowledge and skills. The difference lies in the emphasis and in the amount of time allocated to the various areas of curriculum content, including practice.

In working out an advanced program in mental hygiene, available resources in psychiatric nursing education, public health nursing education, and psychiatric social work education need to be considered. It is believed by many that the training in psychiatric social work is the best formalized training now available for mental hygiene. However, we believe that it is possible, by utilizing all the foregoing resources in two or three universities where they exist together, to develop a program of study pointed especially toward the preparation of the public health nursing consultant in mental hygiene. Since the demand for consultants is very small, it would not warrant such developments in more than two or three universities. If we attempt to develop more than we need or in situations where the resources are not adequate, we shall defeat our own purposes. No university can afford to continue to offer highly specialized programs for one or two students. This *has* happened—with dire results. Since the NOPHN is in a position to see the nationwide picture, with the assistance of the U.S. Public Health Service and the specialists in the various fields, it is locating the spots in the country where there are adequate or potential resources, and will be glad to share this information with universities wishing assistance.

SUMMARY

Our needs fall into four areas: programs of study in public health nursing, in-service education programs, basic nursing curricula, and advanced nursing curricula. If substantial progress is to be made, public health nurses must take an active part in improving education in all four areas. The amount and the way in which we assist will be different, depending on our own jobs, committee work, and other factors. Of the four areas, the needs in the advanced curricula are most imperative at this time because of the war, but also for the very fundamental reason that the experts may be likened to tap roots which furnish the nourishment for the growth of the profession. Without experts, our professional growth will be stunted; without nurses prepared to teach, the progress in the three other areas will be definitely limited. If nursing is to be an art, we must have master nurses.

While admitting that we are not prepared to meet the present pressing demands for experts, this need has been considered, and plans are under way to

meet it. The National League of Nursing Education, the Association of Collegiate Schools of Nursing, and the National Organization for Public Health Nursing are working jointly through organized channels, as evidenced by the report of Miss Fitzsimmons' committee, in relation to the need in the basic curricula; and, in relation to the need in the advanced curricula, by the report of the NLNE Committee on Postgraduate Courses and the work of the special NOPHN group under Ruth Houlton's and Ruth Gilbert's expert guidance.

The Education Committee of the National Organization for Public Health Nursing and its subcommittees were moving purposefully in this direction before the war, but the war has sharpened our awareness and imposed on us a compunction to move faster. The need for experts in the various fields, and plans to meet these needs, are a part of our present as well as our postwar planning. A good beginning has been made in planning the preparation of the psychiatric nursing consultant and the mental hygiene consultant in public health nursing, but it is only a beginning. To paraphrase Elbert Hubbard—The world is moving so fast nowadays that the profession which says something can't be done is generally interrupted by some other profession doing it.

No one has a greater opportunity to assist the people of the country to attain good mental health than the public health nurse. Her contribution is dependent, however, on what we as public health nurses do *today*, individually and collectively, to make it possible. Next year may be too late!

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Improving the School Health Program through Supervision of School Nursing

By MARY ELLA CHAYER, R.N.

HEALTH programs of schools of today are being scrutinized as never before. Among the factors which have contributed to this are the results of the examination of inductees for selective service; the multiplicity of problems of children whose mothers are working; the problems arising from employment of youth of elementary and high school age; the shortage of medical and nursing personnel; the inadequacy of preparation of teachers to assume greater responsibility for health supervision of pupils; and perhaps most important of all, a redefinition of the goals of education toward a curriculum based upon the character of children and the need for children and youth to take their place in a society dedicated to the achievement of lasting peace.

It is assumed that the present shortage of health and teaching personnel will gradually disappear and there is every hope that schools will be able to expand their programs to square with the expanding goals of education.

This monograph* proposes one way of improving the quality of the health program through the employment of well prepared health personnel. The first step toward this expansion would be to provide a high quality of supervision to the school nurses working with children in rural and urban schools.

Supervision is not a panacea for all ills of the health program, but since the work of the nurse contributes to the effectiveness of the entire health program, the supervision of the nursing service is proposed as one important initial step in the right direction.

Since nursing service is sometimes provided by departments of education and sometimes by departments of health, this monograph is addressed to school administrators and public health administrators in order to emphasize the need for supervision and to offer suggestions for the selection of supervisors and for the evaluation of their work.

Why Is Supervision Needed?

Nursing is increasing in complexity. The nurse in the school is in one of the largest and most complex fields of public health nursing. She works with all ages of children from the toddler in the nursery school to the young man and woman in the academic and vocational high school. She works with teachers and parents. She works in all types of schools in all kinds of communities, rural and urban.

In order to help parents and teachers secure adequate care for children, the nurse must keep abreast of the scientific research in the area of child growth and development from childhood through adolescence. She must continuously extend her knowledge of the methods of diagnosis, treatment, and prevention of disease. She must contribute to the better understanding and recognition of children exhibiting signs of emotional mal-

*The outcome of a two-year study by the Committee to Set Up Standards of Supervision for School Nursing of the School Nursing Section, NOPHN. The committee, of which Mary Ella Chayer is chairman, consists of a central committee of 4 and 39 state committees including in all some 178 nurses engaged in school work. This is the first of a number of articles discussing the findings of the study.

adjustments. She must be able to recognize the psychiatric conditions which threaten the child or some member of his family.

To further complicate the situation she is sometimes employed by a department of education and sometimes by a health agency. Under the former plan she serves schools only, while under the latter she usually combines her work on behalf of the school child with all of the other activities expected of a nurse employed by the health department or some other agency.

Since the nurse is only one of the many persons within and outside the school who have responsibility for the health of children, her work must be so clearly differentiated from, and, at the same time, closely related to that of other workers that the contributions of each worker will result in a well-knit program which represents the best contributions of all.

The field of education is broadening. Such publications as *Toward a New Curriculum** and *Education for All American Youth*** clearly point to a broad extension of education downward to include nursery school children, upward to include older youth, and outward to embrace adult education on a broader community basis than ever before. Already in some communities the school day and the school year have been extended and the school program includes summer camps as a part of the educational system. Just as schools cannot expand their offerings in these directions without a strong in-service program for teachers, neither can the nurse cope with these greater responsibilities without expert help.

The importance of inter-community relationships is more and more recognized. Supervision is the time-tested means through which quality of performance has been improved in various professional fields and in industry. Whenever an administrator recognizes the need for supervision, he looks for persons who have intimate knowledge of the work to be done and selects from them one who has skill in working with people. The persons selected will have the responsibility of interpreting to the administrator the needs of the group to be supervised and the administrative factors necessary to the improvement of their work. The supervisor will be responsible for showing demonstrable results. The wider the scope of the program and the more complex the task, the greater the need for supervision. The task of assisting with the health supervision of children and youth for the entire year in home, in school, and in the community is broad enough in itself. If to this are added the problems of helping in the adjustment to civilian life of those young men and women whose education has been interrupted by the war, and if the public school system takes part in this task of community education, then the functions of the nurse in schools will be immeasurably expanded, and the nurse will need all the help she can get both from her own professional group and from other professional workers, including the school administrator and his supervisory staff.

What Can Supervision Accomplish?

Supervision provides a medium for improving the quality of service in all of the community's schools. A community in fulfilling its responsibility to all school children must extend its supervisory service to nurses in public, private and parochial schools, to nursery schools, child care centers, elementary and secondary schools.

Supervision results in a better integrated school health program by helping the nurse to relate her activities to the educational and health objectives of the school. This is achieved by establishing good working relationships with the school administrator, teachers and health personnel; by helping nurses to interpret needs of children to teachers and administrators; by showing how these needs may be used as a basis for health instruction; by developing and defining

*Educational Policies Commission and National Education Association, 1944.

**Department of Supervision and Curriculum Development of National Education Association, 1944.

policies having to do with responsibilities of nurses and other personnel; by working with groups in and out of school for the development of better programs; by utilizing and contributing to the information gathered by guidance personnel for the better understanding and advisement of pupils.

Supervision results in a more unified community health program in which the schools play an important part. Since many agencies and individuals have responsibility for the health of individual children, supervision is needed in order to define, interpret and relate the total program of school nursing to the efforts of other individuals and groups. The supervisor makes use of the contributions from such groups as sanitary engineers, specialists in the fields of child development, adult education, mental hygiene, dental hygiene, nutrition and many other related fields. The complexity of the work of the nurse in schools is such that professional interpretation to school and health administrators, to school boards and to the general public is required.

Supervision results in better utilization by teachers and nurses of enrichment materials for health teaching. One of the purposes of an in-service program is to help nurses and teachers keep abreast of new knowledge in health and nursing and make continuous use of this information in improving the health programs.

Supervision results in a better balance of the total nursing program. The supervisor surveys the needs of the children and their families. She then attempts to balance these needs against the number of nurse hours available, so that the most important aspects of the health program will be safeguarded.

What Should Be the Preparation of the Nursing Supervisor?

A supervisor should have academic preparation and experience in school nursing, and should be selected because of her fitness to work well with people. In addition to graduation from an accredited school of nursing, the National Organization for Public Health Nursing recommends that she have a college degree, which should include the completion of a year's program of study in public health nursing and courses in principles of supervision. She should have had at least two years of experience, in one of which she was under direct qualified nursing supervision in an agency giving emphasis to family health service.

If the supervisor is expected to supervise classroom instruction, she should have teaching experience and preparation in supervision of instruction; or, if she has not had this preparation, she should be expected to secure help from the school's general supervisors of instruction in extending her preparation.

How Can Supervisors Be Secured?

Provision of the school nurse supervision has been a problem. If all the public health nursing supervisors now employed by departments of education, by health departments, and by other health agencies were pooled, enough of them would be available to bring the ratio up to one supervisor to nine public health nurses.* But the ratio of nurses to supervisors employed by public schools is more nearly one supervisor to 46* nurses. The problem is not an easy one to solve, even though it is largely one of distribution and of interprofessional relationships.

Supervision can be secured through a local agency, in addition to such consultant service as may be available through a state department of health or education. The state consultant fulfills a most useful function in helping communities to secure local supervision—often through some existing agency—and in offering consultative service to these supervisors.

An administrator employing nurses for public, private, or parochial schools has several alternatives. He can employ his own nursing supervisor, or he may secure that supervision from some local nursing

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*U. S. Public Health Nursing Census. Total number of Public Health Nurses employed in the United States, in the territories of Hawaii and Alaska, and in Puerto Rico on January 1, 1944, plus 1943 figures for New Jersey which were not included in the 1944 report.

agency in the community. Small schools might better seek the necessary supervision through an existing agency than to try to provide it independently. In some communities small schools secure supervision from the department of education or from the health department. Small adjacent school districts can join together to provide supervisory assistance at little cost to each district. Sometimes a visiting nurses' association will sell a number of nursing hours to schools not needing the services of a full-time supervisor. If services are purchased on a part-time basis, a fairly satisfactory ratio to use in determining how much time to purchase is one supervisor to eight nurses. On large staffs needing more than one supervisor, assistant supervisors may be secured at a somewhat lower salary than the supervisor.

Regardless of the source of supervision, the school administrator should receive the same quality of service as he would from a supervisor employed by his own school system, and the results of supervision should be measured by the same criteria.

What Does the Supervisor Do?

Among 69 supervisors from 19 states who were asked to indicate those supervisory activities which have proved the most useful, the following were given preference:

1. Staff conferences planned for free discussion of problems by the entire staff. Each person is urged to share in the formulation of future policies and programs.
2. Individual conferences and supervisory field visits with nurses in schools and in homes of pupils for the purpose of
   a. Introducing new nurses to their school districts and their responsibilities.
   b. Helping nurses to make good use of community resources
   c. Helping the school personnel and the health personnel to plan the health program together
   d. Helping the nurse to evaluate her own work
   e. Helping the nurse to plan for further professional improvement
3. Planning and participating in an in-service program for nurses and other school personnel based upon their needs.
4. Guidance in professional reading with two main objectives in mind:
   a. Helping to keep the nurse abreast of the advances in the fields of education, child development, medicine, and public health
   b. Helping the school make a plan for a continuous flow of library materials for use of teachers and health personnel
5. Conferences with administrators, principals and teachers for the purpose of
   a. Assisting in determining the objectives of the school health program and interpreting the contribution of the nurse to these objectives
   b. Understanding the administrator's plan for accomplishing these objectives
   c. Helping to evaluate the effectiveness of the program
   d. Assisting the school to make surveys of the needs of children
   e. Assisting in curriculum development, and in the preparation of materials for health education
6. Work with parent-teacher associations and with other community groups in order to coordinate home and school objectives, and to effect satisfactory working relationships with all who can contribute to the health of the school child.

How Should Supervision Be Evaluated?

The program of supervision should be evaluated in terms of an improved, expanded and more effective school health program for the total community and not merely in terms of the improvement in one school or in a group of schools. Since its purpose is improvement in health of pupils and teachers, the school administrator must look for ways of judging that improvement. The following questions are proposed as guides toward evaluation of the program of supervision. It is suggested that the supervisor and the administrator together answer these questions each year, and use the results as a basis for planning subsequent programs.

1. Has the supervisory program resulted in better health for children and teachers?

2. Has the supervisory program resulted in relating the school nurse's work more closely to the entire health program of the schools? Has this closer relationship resulted in a better understanding of the needs of pupils? In relating these needs to classroom instruction? To guidance of pupils and parents?

3. Has the supervisory program resulted in a more healthful school environment for pupils in all schools?

4. Has the supervisory program resulted in a better system of school health records? Have the data thus obtained been utilized in planning the school health curriculum?

5. Has the supervisory program resulted in the better utilization of community resources for health, recreation, and welfare, and in the promotion of other needed resources?

6. Has the program of supervision resulted in more clearly defined school health policies and in a fine delineation of responsibilities of all contributors to the school health program?

7. Has the supervisory program resulted in a better distribution of nursing service to all parts of the community on the basis of needs revealed by a study of the community and its children?

8. In what way has the administrator helped the supervisor attain the common objective of improvement of pupil and teacher health.

9. Has the supervisor given help to the school administrator in evaluating the school health program? In redefining its objectives? In the better selection of school personnel, and in-service education of school personnel which will lead to improved pupil health?

10. Is supervision of school nurses community-wide? What evidence is there that it is expanding to include elementary and secondary schools under public, private and parochial auspices?

11. Does the supervisor participate in a community-wide health program of which the school health program is a coordinate part?

Here then is a picture of today's supervisor in school nursing—her usefulness, the broadening of the field of education in which she works, her capacity for reaching beyond the walls of the schoolhouse into the whole community. What she can accomplish, how she can be selected, what she does, how her work can be tested as to quality—to all these questions this country-wide study of standards and practices has contributed at least a partial answer. It remains for communities to determine how best to utilize school nursing supervision to give impetus and direction to health programs.

TEN WAYS TO PROVIDE NURSING CARE FOR SERVICE MEN

Fighting men need nurses! Only graduate nurses are accepted for the Army or Navy Nurse Corps, yet every one can help to release a nurse for this desperately needed service. Here are ten ways:

1. Keep well.

2. Learn how to care for members of your own family at home, by taking a Red Cross Home Nursing Course.

3. Volunteer for hospital service as a Red Cross nurse's aide or an orderly.

4. Become a U.S. Cadet Nurse if you are eligible, or recruit one.

5. Ask graduate nurses, in the hospital or elsewhere, only for necessary service which no one else is equipped to give you.

6. Release your special nurse as soon as your physician says you do not need her any longer.

7. Ask your local visiting nurse association or nurse's registry for nursing service at home on an hourly basis when needed.

8. Save the nurses' time when you visit a friend at the hospital. Be considerate about visiting hours and extra tasks.

9. Appeal to every nurse and every former nurse you know who is not in an essential nursing position to accept one, and help her to make whatever personal adjustments are necessary.

10. Encourage every nurse you know who has been classified as "available for military service" to apply at once to the American Red Cross or the Surgeon General of the Army or Navy.

—National Nursing Council for War Service, New York, New York

Nursing Internships in Orthopedics

By JESSIE L. STEVENSON, R.N.

THE Joint Committee on Orthopedic Scholarships of the National Organization for Public Health Nursing and the National League of Nursing Education recommends that nurses receiving awards for advanced preparation in the orthopedic field have additional supervised experience beyond the minimum required in the university program of study. The university program cannot be expected to give the amount of clinical practice necessary for the perfection of skills which are essential for the consultant.

The plan which has proved most effective and practical for public health nurses is an internship on salary paid by the agency. Since 1942 the NOPHN orthopedic consultant has assisted in arrangements for internships for 12 of the 28 scholarship nurses who have completed their studies. The previous preparation and experience of the nurse and her scholarship study influence the length and type of internship which the committee recommends. Ten of the internships have been for orthopedic experience and two for experience in supervision, in the general and the special field.

The aims of the orthopedic internship are: to enable the nurse to perfect her skill in physical therapy; to give her experience in orthopedic nursing which was not included in her program of study; and to provide an opportunity for her to apply these skills in the generalized nursing service through demonstration and consultation.

PREPARATION BEFORE INTERNSHIP

The nurse who begins her orthopedic internship has completed an approved course in physical therapy; has preparation and experience in general public health nursing; and, in many instances, has her baccalaureate degree and experience in supervision. The nurse who has an internship planned primarily for experience in supervision has preparation and experience in general nursing, preparation in physical therapy, and two or more years' experience in a public health nursing agency with an orthopedic service. The program of the scholarship nurse prior to her internship and her subsequent experience are both planned to enable her to meet NOPHN recommended qualifications for supervisors and consultants,* and the recommendations of the Joint Council on Orthopedic Nursing for preparation in the specialty.** The combined program of study in orthopedic nursing and physical therapy which the Council recommends is now being offered in one university.***

INTERNSHIP POLICY AND PLAN

The internship policy has developed gradually and is necessarily flexible because of the diversity of background of the nurses. The scholarship applicants accepted in the first two years had, for the most part, adequate experience in the general and special fields. Their scholarship study filled in the gaps in their preparation so that they were ready for supervisory positions in the specialty without further experience.

While the majority of the nurses who have received awards during the past two

*"Recommended Qualifications for Public Health Nursing Personnel, 1940-45." PUBLIC HEALTH NURSING, January 1942, p. 24.

**"Preparation of Nurses for Orthopedic Services." PUBLIC HEALTH NURSING, February 1944, p. 90.

***Teachers College, Columbia University, New York, N. Y.

years have sound background in general nursing, including supervision, they have only limited experience in the specialty. The Scholarship Committee advises a minimum of a year's internship for this group and the award is not confirmed unless the nurse agrees to accept this recommendation.

The NOPHN orthopedic consultant is responsible for discussing with the nurse the reasons why the internship is an indispensable part of her preparation. We have learned from experience that this discussion should precede acceptance of the scholarship. The nurse must decide at this time whether she is able and willing to spend the time necessary to acquire competence in the specialty. The decision is not always easy for she must not only be able to adjust psychologically to a staff position but plan to live on a lower income. If she knows the essential steps in attaining her goal and is willing to make temporary sacrifices, she approaches her internship with wholehearted enthusiasm and considers the experience a privilege.

Agencies releasing nurses for educational leave also should recognize that time is required to produce a specialist. A program of study which requires two years may seem impractical from the standpoint of agency need. However, adjustments frequently can be made. The nurse may return to her own agency for her internship if qualified supervision can be provided, either in the agency or community. Or, arrangements may be made to employ a nurse who has completed her internship. If the orthopedic program in the agency has not been initiated, it is better to postpone it than to expect the nurse to assume responsibilities for which she is not yet prepared. Because the need for orthopedic nurses is urgent and a long time is required to prepare a specialist, it is important to continue training of a limited number even in these critical times.

Several factors must be considered in making arrangements with agencies for the internship experience. The entire program of the agency should be strong and the orthopedic service should provide sufficient variety for adequate experience in physical therapy and orthopedic nursing. There should be correlation between the orthopedic and general services and application of orthopedic principles in the entire nursing service. The orthopedic supervisor should meet recommended qualifications in general and special fields and have interest and ability in teaching.

The NOPHN orthopedic consultant sends to the agency a report of the nurse's preparation and experience prior to her internship, and the NOPHN and the agency confer frequently by letter or in person during the year. At the conclusion of the internship the agency submits a report to the Scholarship Committee which includes an analysis of the experience offered, an evaluation of the nurse's orthopedic skills and her ability to apply these in teaching and in an advisory capacity with the general staff. The nurse also writes a brief evaluation of her experience. These reports are proving helpful in future planning.

Thus far five agencies have accepted NOPHN scholarship nurses for internship. These are the Visiting Nurse Associations of Boston, Brooklyn, Chicago, and Detroit, and the Children's Hospital, Denver. Internship in a hospital was planned for one nurse whose primary need was intensive experience to improve her skills. Her previous public health experience had included supervision and applying orthopedics in the general service.

VALUE OF THE INTERNSHIP

The orthopedic internship plan is still in a developmental stage. Although only five of the twelve nurses have completed the year's experience, the results already are so promising that the Scholarship Committee has recognized internship as an essential unit in the preparation of the nurse in the specialty.

This is the second in a series of articles on the purpose, plan and problems of internship programs.

Internship Plan in the Boston VNA

By MARY MACDONALD, R.N.

SINCE October 1943, the Visiting Nurse Association of Boston has accepted five orthopedic interns for a year of carefully planned field experience under supervision. Two have already completed their year of internship. Before coming to us, four of the five had had very intensive experience in public health nursing as well as in general supervision. The fifth had been a health counsellor, county nurse, and college health education instructor.

Since the intern receives some vacation, she is actually with us less than a year. Although we plan her experience around her individual needs, in general, we divide her internship into three periods.

At the beginning of the first period, which includes two to four months, we assign the intern to a district station in which the monthly total of physical therapy treatments exceeds eighty. This district office remains her headquarters for the entire internship. During this period, she observes in the field with the orthopedic supervisor and orthopedic staff nurses, has weekly conferences with the orthopedic supervisor, audits lectures and demonstrations on orthopedic nursing techniques, and observes at key clinical and teaching centers in the city. She gives a great deal of direct service and invites the orthopedic supervisor to visit all her patients in the home with her. After the first month, she participates actively in any orthopedic educational project which the office staff may wish to present. She rarely gives consultant service in the field; she may occasionally demonstrate the less complicated techniques about which she, herself, feels very secure.

Our policy at first was to discourage informal office conferences between the intern and the staff nurse; we feared the intern might be embarrassed if she could not answer the casual but difficult questions often asked by the staff nurse. We found it impractical, however, to pursue this policy because the staff nurse inevitably gravitated toward the enthusiastic intern and we discovered that the intern handled such situations well.

During the second period, the intern assumes responsibility for the demonstration of selected treatments to the staff nurses in her station. A conference between the intern and staff nurse precedes and follows such a demonstration. The intern is also responsible for the specific written instructions regarding each treatment. She continues to give direct service and to confer periodically with the orthopedic supervisor, who also visits in the home with her on selected cases. At this time, she usually has a class of Senior Cadet nurses to whom she teaches the orthopedic content of their orientation course in public health nursing. We stress during this period the community aspects of orthopedic care, and try to arrange observations at agencies interested in other phases of rehabilitation.

During the last two months of the internship—the third period—the orthopedic supervisor delegates to the intern complete responsibility for the orthopedic program in her home station. The intern calls for assistance only if a difficult situation arises. This period gives her an opportunity to judge on a small scale how well she is equipped to function independently. The Association, too, can evaluate the training which it has given to the intern.

Sometimes the intern wishes to secure more experience in the care of the patient acutely ill with poliomyelitis. If this experience is not available in Boston, we might approve her going to an epidemic area for a period not exceeding two

months; we would consider this experience a unit of her internship. She must, however, work under the medical supervision of an orthopedist or a doctor of physical medicine and have at her disposal technical supervision from a teaching physical therapist experienced and skilled in the techniques of muscle re-education. Since this intern plans to be a teacher, we feel strongly that she cannot afford to discover the best techniques by the trial and error method as she must necessarily do, if she works alone, or with inadequate medical and technical assistance.

The intern may carry a few general cases but the number of such visits should not exceed one quarter of her total case load. We expect her to be completely responsible, when possible, for the nursing care and health supervision not only of the orthopedic patient but of his entire family.

The intern keeps an experience sheet which she forwards monthly to the orthopedic supervisor. This sheet tallies the amount of direct service given, the number and type of office and field demonstrations, the topics of group discussions, her conferences with all supervisors, clinic observations, contacts with family and community agencies, and the number of cases not of an orthopedic nature. This report is of immeasurable value in planning the year's experience.

Our problems were, on the whole, not as numerous as one might anticipate starting a new project. That the Boston Visiting Nurse Association was geared to educational projects helped tremendously, of course. Our first problem was travel. The intern became very tired from walking long distances. Realizing a shortage of nurse power existed, she worried because her case load was way below average since so much time was consumed going from one patient to another. With the help of an understanding administration and the OPA, the agency purchased additional cars and the travel problem ceased to exist. The psychological trauma which might be expected to result from a temporary but substantial reduction in salary and professional status apparently is non-existent when the intern herself is convinced of the need of this year's experience. Whether the rapid turnover in orthopedic personnel, such as occurs in an internship project, will have any disturbing influence on the stability of the orthopedic program in general, is as yet to be determined. To date our experience has been too limited to permit our coming to any conclusion.

The orthopedic intern, in our opinion, makes a very definite contribution to the agency. First of all, she has a particular kind of skill which she places at the disposal of our patients who need that type of specialized treatment. In addition to this, she is an unusually well prepared, experienced public health nurse with a generous allowance of all the fine qualities which that name implies.

This, together with the articles, "Internship" by Ellen L. Buell in the January 1945 issue and "Nursing Internships in Orthopedics" by Jessie L. Stevenson, page 80, this issue, comprises the complete series on the purpose, plan and problems of internship programs. The series will be available in reprint form through the Joint Orthopedic Nursing Advisory Service, 1790 Broadway, New York 19, N. Y., by April 1, 1945. All JONAS reprints are free.

Emergency Volunteer Home Aide Service

A NEW SERVICE has been offered to the community by the Visiting Nurse Association of New Canaan, Connecticut. Realizing that in many homes sickness may come suddenly, either to the mother or occasionally to the whole family, leaving no one available to take charge of the home, a group of volunteers has offered to act as emergency volunteer home aides. They have agreed to go into these homes, at the request of a doctor or a visiting nurse, to help out when such a situation exists. These volunteers are graduates of the Red Cross Home Nursing Course and

have received additional instruction to fit them to carry on this service.

This is a supplementary service to the community sponsored by the Visiting Nurse Association in order to help meet the wartime emergency. The home aides have offered their services on a purely voluntary basis in a desire to be of help and they cannot receive any remuneration or gift of any kind, nor can they go into any home except on an order from the attending physician or the visiting nurse. They do not give any sort of treatment, but may give routine nursing care such as taking temperatures, giving bed baths and backrubs, making beds, preparing diets or fixing the baby's formula. They report for duty for a definite length of time ranging from one to four hours, when called by the doctor or the visiting nurse, and are directly responsible to the directors who are themselves registered nurses.

In many cases what is needed is someone who can take charge temporarily so that the mother may stay in bed long enough to get well or until she can get permanent outside assistance. This may involve preparing meals, either for the sick person or for well children, straightening the house, or doing any one of a number of things which may be urgently needed.

Thirty-eight women have already volunteered and been trained for this service and it is expected that if more are needed it will not be difficult to recruit them.

New Canaan is fortunate in having a group of women who can make this service possible. Just as the visiting nurse goes into every home where she is called, rich or poor and regardless of ability to pay, so these home aides are ready to go wherever they are needed and can be of help.

OUTLINE OF INSTRUCTIONS AND DUTIES OF VOLUNTEER EMERGENCY HOME AIDES

I. Duties
1. To keep a detailed written report for director (to be telephoned at end of duty)
2. To report for duty for a definite length of time
3. To work quickly, efficiently and quietly
4. To accept no remuneration of any kind
5. To keep all conversations and events that occur while on duty strictly confidential
6. To be tactful, cheerful and courteous at all times

II. Care that can be given
1. Take and chart T. P. R.
2. Prepare diets and baby's formula
3. Bedbaths and sponges
4. Backrubs
5. Make or straighten beds
6. Give a.m. and p.m. care
7. Bed pans, commodes and bathroom
8. Get convalescent patient into chair or back to bed
9. Entertain patient, i. e. read, play games, etc.
10. Carry out *WRITTEN* orders of the doctor and *only* written orders aside from routine care

III. Helpful things which could be done

Individual judgment should be exercised in this, remembering that you have volunteered to be "helpful," but not allowing yourself to be imposed upon
1. Washing dishes
2. Preparing meals
3. Straightening house
4. Taking care of well children

MRS. CARLYLE H. BLACK, PRESIDENT
VISITING NURSE ASSOCIATION OF NEW CANAAN, CONNECTICUT

ATTENTION!

Please notify us of changes of address as early as possible. Six weeks' notice is necessary to affect the magazine mailing list.

Chronic Illness in Connecticut in 1944

By KARL F. HEISER, Ph.D.

OVER the past twenty-five years it has become more and more apparent that the sociological results of the increased life span and urbanization of homes and occupation were rapidly reaching a point at which social action was imperative. The Connecticut General Assembly of 1943 directed that a study be made of the needs of the chronically ill and aged, specifically of the need of a state infirmary for their care. This study has been made by the Research Division of the Public Welfare Council and concrete proposals laid before the 1945 General Assembly. It is the purpose of this article to describe this study, to discuss some of the problems presented, the methods developed and used, the findings of the study, and the recommendations which have been drawn up for governmental action.

BACKGROUND

Very briefly the general setting and background of the investigation and present situation are these. Connecticut is a small state with a population in 1940 of 1,709,000. By 1944, due largely to war industry expansion, it had increased to about 1,760,000. About 43 percent of the total population live in 6 of the 169 towns. Within a radius of 15 miles one may find most modern or highly urbanized environments and rural areas of extreme cultural isolation in which plumbing, electricity and telephones are hardly known. Although it is probably best known as the center of the American insurance business, it has a widely diversified industry. Agriculturally it is prominent for tobacco, dairying, and fruit farming, but most of its land is of only marginal or sub-marginal value. Throughout its area there is a large proportion of foreign born or first generation American citizens.

Due to the war, the state had reached a peak of economic activity in 1944, at which time the public relief or assistance rolls had reached a low of approximately 2 percent of the population. In normal times the chief need of public assistance seems to be due to unemployment, while in 1944 the need was based largely upon unemployability. While welfare policies and programs have been largely devoted to economic support of the needy, there have been adaptations of welfare programs to provide for hospitalization and medical care of the indigent sick. Of the 6,000 persons supported by the towns, over a fifth were resident in 39 town farms or poor homes in which care ranged from room and food to general hospital care.

The Public Welfare Council is a body of five leading citizens appointed by the Governor. They serve in an advisory capacity without pay to the state government and to the various welfare programs operated by and within the state. The Council's Research Division was established as a means of scientifically getting and interpreting facts in the various fields of welfare as a basis for the policies and recommendations of the Council.

PROCEDURE AND METHODS OF STUDY

Although the state is concerned with the health and welfare of all its citizens, the immediate problem for this study was presented by the indigent group which is largely the responsibility of the state and the towns. The major part of the study was confined, therefore, to recipients of public assistance, but data were obtained also from a number of hospitals and private agencies.

The method followed was to train research assistants to read through the case histories and to record all pertinent information wanted in the study. Preliminary study of these records revealed that not all the information that might be desired could be found. Only those facts

which seemed to appear with sufficient frequency and validity were abstracted and indicated on prepared code sheets. The preparation of these code sheets was a task that required considerable planning as well as knowledge of statistical machine methods. The following information was coded on these prepared sheets and then punched on 80 column Hollerith cards:

1. Case number
2. Address
3. Previous address
4. Chief illness
5. Secondary illness
6. Date of birth
7. Place of birth
8. Sex and marital status
9. Duration of present residence
10. Type of present residence, (i. e., living alone, with family, in hospital, etc.)
11. Type of previous residence
12. From what source receives assistance
13. Amount per week of public assistance
14. Amount per week of private agency assistance
15. Amount per week of assistance from relatives or friends
16. Number of agencies giving assistance simultaneously
17. Present earnings
18. Education
19. Last chief occupation
20. Presence of mental disorder
21. Present type of care received
22. Type of care needed
23. Quality of present care
24. Physical status—(bedridden, wheelchair, partially or wholly ambulatory)
25. Possibility of vocational rehabilitation
26. Who made diagnosis of chief illness
27. Duration of chief illness
28. Duration of incapacity
29. Future duration of incapacity
30. Sources of information on case

Tabulations could be made from the code sheets of the distribution of any one of the above factors or of the interrelationship between any number of factors, e. g., it could be found very quickly what proportion of widowed women living in rooming houses in one section of Hartford were crippled with rheumatism as compared with the same group in a rural town.

AGENCIES

The files of seven state welfare or health agencies, town welfare and town farms or homes, Workmen's Compensation, private hospitals, institutions and nursing agencies were studied. This meant sampling about 35,700 records.

The sampling technique varied with different agencies according to their number and distribution of cases. For example, there were 4,102 cases in the active file of the Division of Crippled Children. An alphabetic sample of 36 percent of these records was made. Since Old Age Assistance records were filed by towns, the sampling in this agency was done on a town by town basis. If a town had 100 or fewer cases, all records were read, if there were 101 to 200 cases, 80 percent were read and so on to a 20 percent sample of all records in towns that had over 1,000 cases.

In all agencies the sampling system was devised in order to get the most reliable estimates with the available time and budget.

As would be expected, the case records varied from agency to agency, due to the type of agency and the nature of the case. Some records were complete social case workers' records and were orderly, written in simple English, and were scientific or objective in their appraisal of situations. On the other hand, some case histories consisted of a monthly entry of a name and monetary figure in a ledger. In all cases, it should be said that these case histories, from good to bad, represented what officials or case workers were directed to do; they represented what these people thought adequate in the situation and what custom required of them. In those hundreds of instances in which the case history consisted of a name and disbursement figure, the research worker would interview the agency official who handled relief to get a more complete story.

The chief obstacle in the finding of evidence of chronic illness through the study of case histories was found in the orientation of the case worker toward her or his job. As a rough generalization, it may be said that the workers of these agencies were trained to think in economic terms of food, clothing and shelter costs, in terms of how much money was necessary to support the recipient according to the standard which his community would demand for him. Different communities naturally have different standards of subsistence and any one community has different standards for different assistance clients. The "town drunk" may go to the town farm but the community's respect for the doctor may determine that his widow go to a private hospital at four times the cost to the town.

Because of the economic concentration of the social workers' interests, it is rare that the worker sets a definite objective of including a complete medical or health record in her report. Many reports were like the following: "At time of visit, Mrs. X had been confined to bed for some time and was unable to get up and tend

to her housework. She had had the doctor come several times since my last visit." Several doctor's bills would be inserted in the record on which the dates of his visits and his charges for examination and treatment for heart could be determined. From this the research worker could code heart disease, its duration and authority for diagnosis.

Because of the nature of the case histories, the number of coded reports of chronic illness which were made by the research workers varied between agencies. For example, evidence of chronic disorder was found in about 70 percent of the recipients of Old Age Assistance, but in only half of the general relief clients of towns.

DIAGNOSTIC CATEGORIES OF CHRONIC ILLNESSES

The selection of diagnoses to be coded was a very important part of the preliminary work of the study. The following objectives were drawn up before a code list of illnesses was adopted:

1. The list of diagnoses should be comprehensive and should be significant both to physicians and authorities who might be charged with the institutional and nursing care of the patients.

2. The diagnoses should be in terms which the lay reader would understand.

3. The list should be as short as possible to simplify coding and statistical handling. Any one particular disease might have several subclassifications but they should be used only when they make a real distinction possible as to the condition of the patient, his needed medical or nursing care, and his prognosis. It was decided that only those diagnoses should be included which might include a minimum of 1 percent of the cases to be found.

On these problems, the assistance of an advisory committee of six leading Connecticut physicians, and occasional aid from other physicians, was invaluable as was, also, the guidance gained from previous studies of this sort.*

It was desired that the diagnoses be classified or grouped for the convenience of coding and statistical tabulation. The 18 classifications given in the Manual of the International List of Causes of Death** were condensed to 12 and under each group heading there were from 2 to 10 sub-classifications of disease, in all 63 subclassifications. It should be pointed out that half of the patients had two or more chronic illnesses and that in all such cases the guidance of the manual*** and of medical advisers was followed in selecting the chief and secondary illness. The chief illness might not always be the most likely cause of death, but it was the one that was most handicapping to the patient or the most serious in preventing self-care.

Table I gives the statewide results for all agencies. The large numbers of cases in certain categories are due mostly to the inclusion of agencies for crippled children, mental defectives and the blind.

FINDINGS

Table 1 shows the chief disorders found in 26,000 persons. As is to be expected, certain diseases, e. g., of the heart, rheumatism or arthritis, and diabetes, are prominent in number and some are more prominent than their numbers indicate. For example, heart disease is in the background for many of those included under Diseases of Nervous System and Sense Organs, particularly paralysis; and under the kidney disorders.

Table 2 gives a condensation of the age table by type of chief illness and shows that 76 percent of the total are adults and that 29 percent are over 75 years of age.

The present study was primarily concerned with adults, particularly the aged, as the most apparent problems of care have developed with them. Table 3 indicates the present physical status of the patients of the "adult" agencies.

Women constituted 55 percent of the total group of adults and 55 percent of them were separated, divorced or widowed. Only 35 percent of the men were in this latter category.

The bedridden and partially ambula-

*Bigelow, G. H. and Lombard, H. L. Cancer and other Chronic Diseases in Massachusetts. Houghton Mifflin Company, New York, 1933.

Jarrett, M. C. Chronic Illness in New York City, Vols. I and II. Published for the Welfare Council of New York by Columbia University Press, New York, 1933.

United States Public Health Service, Division of Public Health Methods. National Health Survey, 1935-1936, Sickness and Medical Care Series, Bulletin No. 6, "The Magnitude of the Chronic Disease Problem in the United States." Washington, D.C., 1938.

**U. S. Bureau of the Census. Manual of the International List of Causes of Death (Fifth revision) and Joint Causes of Death (Fourth edition), 1939. Government Printing Office, Washington, D.C.

***(*Ibid*).

TABLE 1.
CHIEF ILLNESSES FOUND IN 26,000 PERSONS

Diagnosis	Total number of cases	Number in certain selected diagnoses
Epidemic and communicable	1,219	
Poliomyelitis (deformity and paralysis)		593
Rheumatism, nutritional and general diseases	3,192	
Rheumatism and arthritis		2,034
Diabetes		713
Diseases of heart, circulation and blood	5,572	
Diseases of heart		3,653
Diseases of nervous system and sense organs	7,231	
Paralysis		1,052
Mental deficiency		1,044
Blindness		1,826
Diseases of eye or ear		1,584
Diseases of respiratory system (non-tuberculous)	458	
Diseases of digestive system	1,119	
Diseases of genito-urinary system (non-venereal)	613	
Diseases of skin, bones and muscles	596	
Deformities, malformations and results of accidents	3,584	
Birth injuries and congenital defects of nervous system		802
Orthopedic disorders (non-poliomyelitic)		902
Congenital malformations (except central nervous system)		662
Old age and senile deterioration	1,321	
Feebleness due to age		859
Cancer and other tumors	505	
Ill defined and other diseases	593	
Total	26,003	

tory patients present the most serious problems of care and the greatest need of hospital or infirmary disposition. Table 4, which indicates the present type of residence of these two groups, shows that a very large percentage (40 percent) are already removed from their own homes or families and would probably, therefore, be more apt to apply for admission to new state institutions than those patients cared for at home.

The above tables present in condensed form some of the more important summarizations of the findings. From them, one may easily construct a theoretically ideal program of care and treatment. However, ideal programs are not built merely by the method of logical induction from a few known facts. Data, such as the above, are merely the facts one seeks when he wants to undertake a program and needs only to outline the detailed plans. More important than such data are less tangible but quite objective factors which may be classified roughly as follows:

1. Scope and level of present public health program.
2. Professional skills and knowledge of the chronic diseases.
3. Attitudes of officials and the public toward public assistance recipients and the chronically ill.
4. Standards of living and real wealth of the population.
5. Fiscal and taxation policies of government.

These are the important factors and forces which must be organized and integrated before active and progressive steps to deal with the problems presented by the present type of study may be taken. The fairly universal lag between the ideal goals set by scientists and professional people and the programs of action undertaken by government is a very

TABLE 2.
AGE DISTRIBUTION BY TYPE OF CHRONIC ILLNESS

Disease type	75 years and over	20 to 74 years	Under 20 years	Age unknown	Total	Median age
Epidemic and communicable	29	406	703	81	1,219	17
Rheumatism, nutritional and general diseases	1,067	1,949	124	52	3,192	72
Diseases of heart, circulation and blood	1,883	2,848	694	147	5,572	71
Diseases of nervous system and sense organs	1,903	4,194	990	144	7,231	65
Diseases of respiratory system (non-tuberculous)	105	287	52	14	458	68
Diseases of digestive system	414	661	17	27	1,119	72
Diseases of genito-urinary system (non-venereal)	228	335	35	15	613	72
Diseases of skin, bones and muscles	113	200	267	16	596	28
Deformities, malformations and results of accidents	303	753	2,471	57	3,584	14
Old age and senile deterioration	881	422		18	1,321	75+
Cancer and other tumors	145	326	19	15	505	72
Ill-defined and other diseases	185	345	25	38	593	71
Total	7,256	12,726	5,397	624	26,003	68 years
Percent of total	29	50	21		100	

real index of a large gap in the social science of our culture. This gap is a large area of darkness into which there are occasional flashes of light from the fields of government, political science, economics, sociology, psychology and public administration but the area, in general, remains to be illuminated by a fusion of permanent light from these and other sources.

This is not the time or place for a discussion of these five important factors but it may be said, without bias, that Connecticut is in a relatively fortunate position with regard to them. In some instances, notably factors 1 and 2, Connecticut is quite advanced among the states.

A few comments with regard to factor 3 might be of interest. The attitudes of officials and the public are consistent with the relief philosophies and policies mentioned above, i.e., these problems are generally approached in economic and moral terms rather than in terms of social science and public welfare. Attitudes derive broadly from the old philosophical concepts of "freedom of the will," personal independence and responsibility. It follows that current attitudes largely represent the feeling that public assistance recipients are responsible and to blame for their economic, social and bodily plights and that they do not deserve the standard of living and social welfare that are enjoyed by the self-supporting population.

The attitudes that are expressed are largely relative to or dependent upon the frame of reference aroused by questions. For example, if one asks about the care of the town farm chronic drunk, one gets certain fairly specific attitudes; questions about care for the indigent chronically ill arouse a variety of answers; and questions about the care of victims of poliomyelitis and cancer arouse fairly specific answers, usually of a quite different sort from the others suggested above. Questions about infantile paralysis arouse the easily expressed sympathy for children; the fairly widespread knowledge of one's statistical chances of dying from cancer certainly color one's attitude toward that particular problem.

What is most needed for the effective integration of the above five factors is a practical and conclusive scientific test and affirmative demonstration of the theory that *everyone gains economically* from the prevention of disease and the maintenance of health and productive capacity of the whole population. The suspicion that only the indigent and sick gain at the expense of the wealthy and healthy must be aired and tested, for, so long as that suspicion remains, little will be done in this field.

RECOMMENDATIONS

The recommendations adopted and presented to the legislature were determined by five chief goals:

1. Better medical care and treatment.
2. Development of preventive policies through research.
3. Maintenance of as many patients as possible in their own homes and families because of greater emotional satisfaction of patients and probable greater contributions toward care by family.
4. Utilization of all present facilities for health and medical care.
5. Reasons of economy.

It is not claimed that the following recommendations, which were developed in consequence of the specific needs revealed by the study, are the best that might be made but they are the best for the present situation in Connecticut in the judgment of the Public Welfare Council. It is urged that the recommended program be adopted as a whole and that immediate steps be taken to put it into effect, though it is not expected that the program may be fully developed for several years.

For the immediate present it is recommended that a new commission be established with power and funds to develop and institute the following program:

1. A marked expansion of the present public health nursing services in the state. At present there are about 525 positions established for nurses in public agencies and in private visiting nurse associations. To bring the number up to a satisfactory standard of one nurse for 2,000 people, about 350 more positions are needed. The proportion of public health nurses who do bedside nursing in

TABLE 3.
PHYSICAL STATUS OF THE ADULT GROUP BY AGENCY

	Old Age Assistance	Towns and town farms	Agencies for the blind	Private and other agencies	Total	Percent
Bedridden	733	419	7	740	1,899	11
Partially ambulatory	2,714	1,006	1,260	711	5,691	33
Ambulatory	5,684	2,246	488	1,183	9,601	56
Unknown	1,698	367	476	126	2,667	
Total	10,829	4,038	2,231	2,760	19,858	100

TABLE 4.
PHYSICAL STATUS OF THE NON-AMBULATORY ADULT GROUP BY TYPE OF RESIDENCE

Residence	Bedridden	Partially ambulatory	Total patients	Percent
Living alone	32	611	643	11
With own family	571	2,347	2,918	49
Rooming or boarding	146	782	928	16
Convalescent hospital	382	229	611	10
General hospital	171	33	204	3
Other*	198	460	658	11
Unknown	399	1,229	1,628	
Total	1,899	5,691	7,590	100

*Mostly town farms

the home should be greatly increased.

The nursing bodies should be so organized as to facilitate effective dealing with the state and the representation of nursing needs and interests to the state.

The state should pay for bedside nursing care on a fee for service basis, just as it now pays the physician who calls on public assistance recipients.

Since there is a great need in many homes for housekeeping services, a housekeepers-aide corps should be established, probably under the supervision and pay of the nursing agency.

The mechanics of establishing minimum standards of nurses' training, supervision, and salaries should be developed.

2. Some forty out-patient clinics need to be established or comparable services made available in present clinics in general hospitals for consultation, diagnosis, and some treatment of assistance recipients. These clinics should be staffed by physicians employed by the proposed state commission, and from the local hospital or community so that the two groups of physicians may interchange ideas and techniques.

The cooperating general hospitals should be paid for the use of their clinic space, their special equipment and personnel services.

3. At least five regional infirmaries to accommodate 3,000 patients are needed at once. Each infirmary should have a resident staff of graduate nurses, a dietitian, occupational therapist and the usual food service and maintenance staff. Medical, psychiatric, psychological and social services should be supplied by a central professional staff of the commission. These specialists should make periodic visits to all infirmary patients and should be available at all times. In addition, there should be a consulting staff of physicians in the vicinity of the infirmary.

4. One thousand new general hospital beds are needed for the intensive treatment of acute phases of chronic illness, e.g., cancer treatment and surgery. These beds may be established in the general hospitals of the state, or in two new state hospitals or by some combination of the two systems. In any case, provision should be made for concerted study and treatment of certain types of cases so that they are not left to the uncoordinated policies of the many different private hospitals.

5. One thousand new beds should be established in five new state boarding homes for the aged. These homes should have the services of resident nurses and physicians from the state commission and the community but they are not to be considered as medical institutions.

Some suites should be provided for married couples and facilities made available for recreation and useful occupation of the aged residents.

6. The commission should be provided with state funds, and empowered to accept and administer private funds that may be given to it, for carrying on well planned and integrated research programs in the field of geriatrics and chronic illnesses.

It is impossible at present to estimate the building costs of the proposed institutions because one cannot now foresee the costs of labor and materials, the possible adaptation of some present facilities and the extent of federal participation in such construction costs.

Likewise, it is difficult to predict operating costs of this program. However, on the basis of past experience with similar services, it is estimated very roughly that the initial capital costs of new construction, without the use of existing facilities and federal grants, would approximate $7,000,000 and that the annual operating costs, including interest and depreciation, would approximate $4,000,000. This latter figure includes $100,000 for research and training and assumes that the 1,000 hospitalized patients are in state operated hospitals. It includes $200,000 for home nursing and $150,000 for clinic care, which would tend to increase in time.

It is estimated that the above program would increase the welfare expenditure of the state and towns approximately $1,000,000, but it should certainly insure more adequate medical care to a

larger number of people and should improve the general welfare and productive capacity of the population.

It is further recommended that the medical, health and welfare problems of the state should be considered in over-all perspective, rather than in state vs. town problems, in relief cases vs. self-supporting people, in chronic diseases vs. acute illnesses, in state vs. private hospitals, in state vs. federal programs, and that the present recommendations be followed primarily for the solution of the immediate problem of the indigent but, in the long view, for the good of all citizens of the state.

DIVINITY STUDENTS LEARN ABOUT HOSPITALS AND NURSING

PART of the preparation of every student in the Philadelphia Divinity School is three months' service in the hospital working with selected patients. This phase of his training is intended to develop the student's Christian relationships with the patients and to bring about an understanding of the factors, social as well as spiritual, that contribute to their recuperation.

Each student is given the opportunity to become thoroughly acquainted with the different departments of the hospital; to know the work of the doctors, nurses and social workers; to understand the causes and preventive measures that can be taken in treating different patients. One out-patient, chosen with the help of a medical social worker, is visited regularly in his home and a religious history is written of him and his family.

To promote cooperation in the hospital and after the students' graduation, explanation of their work is given the students by the director of the nursing school and all the supervisors. In my report to the student group, I interpreted the different phases of the public health nurse's program in a community, using "Functions of the Public Health Nurse" as a guide. I stressed the fact that her services are not restricted to the indigent patient and that fees are usually determined on a sliding scale. Human interest stories were used to illustrate the use of churches and social agencies in the care of patients and their families. I emphasized particularly the help that ministers can give the public health nurse by referring patients to her or by reporting those who seem hesitant about requesting nursing care when they need instruction primarily. This is often true of antepartum patients, infants, preschool children, and those with communicable diseases.

Questions asked during and following a two-hour seminar showed genuine interest on the part of the students. Their queries included the following:

When the problem seems to need both social and nursing care, which agency should be notified?

May a visiting nurse be called to a family where poor management in food and rest habits seems to be the problem?

Would a nurse visit an orthopedic patient of long standing who is under the care of a private physician?

Are public health nursing services extended to those who need hospital care, but refuse to have it? (Heart patients were cited.)

How long would a family be kept under supervision where one member of the family has been sent to a sanatorium for care of tuberculosis?

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"Way Down East in North Carolina"

By CAROLINE E. KIDDER

FORTY MILES down east in Carteret County is Cedar Island, the farthest end of my district save Portsmouth on the Banks. The Inland Waterways make it an island. It is not difficult for the nurse to get to these people once a month, but the distance is long for them to travel to a dentist or a doctor.

Milk, fruit and vegetables are scarce in all the outlying places, though all kinds of sea food are abundant. There is also game in season, including deer. I have seen two this fall vanishing down the road ahead of me—on fenders of cars! I have had the joyous sight of blue, white, and green herons on the wing and a bald eagle.

Hookworm is a menace to health in this county. It is a problem hard to meet, conditions causing the disease not being easily changed—where water is so near the surface of sandy soil, wood for building scarce because of war needs, and full understanding lacking in many homes.

It is difficult for the parents of the county to meet in groups because of lack of transportation and help at hand to care for the children, and also the age-old individualism that seems to keep fishermen like mountaineers from understanding the need of an exchange of ideas and help. We have no group services at present.

Books on family living and marriage were lent to the county health office by the North Carolina Library Commission. In turn, we lent packs of five to ten books to responsible persons for distribution locally. "If I only had had the understanding I got from these books when I was starting my home," is a frequent response. "My son read *Attaining Manhood* and put it down on his school reading list under the heading, 'Self Improvement,'" was another. Probably 80 persons read the books, mostly adults.

Parents are eager to have hot lunches in the schools. We have flourishing ones now in two schools and others are being talked of.

Last year the North Carolina State Board of Health began the method of teacher physical inspection of pupils. The doctor visited the schools to explain and demonstrate the procedures. The teachers proved eminently capable of carrying through the work and were praised for the good service. In the summer, home calls were made by the nurse on the parents of children who were found to have serious handicaps. In the fall, the service was followed up by classroom visits when each pupil was given time to report his corrected handicaps before classmates, teacher and nurse. Appropriately those with perfect records also reported.

One day the doctor and I went by boat to visit the school at Lukens. As we walked down the dock and stepped onto the ground a girl came up to us and said, "Are you the doctor and the nurse who were to come and visit our school?" "Yes," we said. She continued, "I am the president of the school, this is the vice-president, and this is the secretary. We will go with you to the school. Can we carry anything?" This was the introduction of the Health Department personnel to the representatives of the one-room school located in an isolated spot of Carteret County reached only by boat.

Our reception at the school house was like that given warm friends in a family's living room. The one-room school was cozy, pretty, light and airy. The children had covered an old folding screen with bright flowered cretonne. An old bench, which they had painted light green, had

a rather high back and when it was moved away from the wall, it served as a coat rack. Each child had brought a hanger from home.

From orange crates, they had made recitation arm chairs, painted them light green, and made cretonne covers for the backs. The curtains were ordinary gauze or cheesecloth, painstakingly tied and dyed by the children. A bird feeding station had been built outside one of the windows, and the children knew the name of the unusual warbler who patronized it.

The seats were arranged from corner to corner for best light with the seat for a left-handed boy placed so that the light came from his right. On the wall was a map of South River watershed with the location of the children's homes marked on it. All the children helped to make it.

Around the piano, which had been lent to the school, the children gathered and sang with low sweet voices.

Each boy and girl served on a committee. These committees covered activities such as sweeping and dusting, preparing and serving lunch, cleaning blackboards, arranging flowers and caring for their containers, checking on the ventilation in the room, cleaning toilets, making maps, caring for wraps, desks, stove, and playground, and meeting visitors. The various committees were written on the blackboard.

The teacher, Grace Wilson, said, "We keep the room just as clean as we know how to keep it. Yes, we have a special place for the dust cloths and the mops. Each time after we use them, we clean them and put them away. The cleaning program also provides that the tops of the desks be washed at least three times each week, that the windows be kept clean, and that curtains and flower vases be washed. Of course, the children are as clean as the room."

A stand had been built around the pump and a trough had been constructed beside it, and each had been painted light green. Each child washed his hands with soap before lunch and was supplied with paper towels and napkins for his desk at lunch time. The playground was kept in an orderly manner and the toilets were spotless and odorless. There was a regular time for each pupil to be excused.

As we talked with the teacher, answers to questions came like this: "We are living the health project for we believe that schools should be places where we want to live. For instance, one day at recess we had carrots which we scrubbed and divided lengthwise. The children said, 'We shall plant some of these.' We are evaluating what we do, for example, we found that curtains need careful measurement as we had to make them over several times."

"Making puppets, which is to be our next recreation project, will require cooperative effort from all of us. Perhaps our outstanding physical needs are the balanced diet, the prevention and cure of infected tonsils, and dentistry."

A teacher in Beaufort, with her 33 seventh grade pupils, has completed a "school project"—the study of lighting the school room for the conservation of eyesight. In using a light meter, which was borrowed from the School of Nursing at the University of North Carolina, the class ran into questions of county-wide interest like "What color, kind and texture of shades are needed in schools to diffuse the best light to every desk?"

The nurse was given a report of the study with this final paragraph.

"Now we think this unit on lighting has been beneficial to each pupil in the school. In it we correlated English and spelling in our oral discussion, and letter writing; arithmetic, in our measuring the room and making scale drawings; geography, in the use of compass and directions; reading, in the study of each pamphlet received; and lastly, health, the first objective of education and life, which was the basis of our study.

In conclusion the aim of this unit to know how to properly light a room has been accomplished. We are now light conscious!"

Do you like your job in Carteret County? That I do, to be sure.

A portion of this article appeared originally in the *North Carolina Health Bulletin*, August 1944.

Testing Functional Ability in the Orthopedically Handicapped

By MARJORIE P. SHELDON

TRAINING IN functional activity is that part of orthopedic care which teaches the patient how best to use his strengths in practical living—walking, stair climbing, essential hand usages, self care. It is primarily concerned with the *minimum activities* which enable him to go through an ordinary day without help. The first interest of the orthopedic nurse and physical therapist is to be sure that each of her patients is taught to perform to his maximum capacity as many as possible of these essential activities.

Training for functional activity may be a haphazard affair unless we have some means of gauging the individual's actual ability in this respect. Such a method is contained in "The Essential Activity Test for Orthopedic Use" developed at Branch Brook School in Newark, New Jersey. It has been in use there as a part of the orthopedic physical-education program since 1930. Although devised for special school use, this test is applicable to any orthopedically handicapped person, child or adult who is past the acute stage of his illness or injury. A measure of functional ability, such as this test, serves several purposes in the orthopedic program.

First, it determines the need of the individual for teaching help in acquiring certain skills.

The person who has a residual handicap from orthopedic illness or injury is at a severe disadvantage when it comes to learning or re-learning how to get about and take care of himself. He usually lacks normal muscular strength or control. He is habituated to inactivity. He may have unlimited courage and still be forced to a relative idleness because he lacks the technical ingenuity to work out his motor problems. Stair climbing, for example, may be perfectly possible to him if he is taught just how to combine body weight, balance, muscle strengths and use of crutches to the best advantage. Even when he has learned the skill he must be given opportunity for practise under protection until he becomes easily able to handle himself.

The activity test, therefore, helps us to pick out those weak spots in the patient's functional background which are possibly amenable to improvement; nor may we take anything for granted. The fact that a patient's muscle test shows sufficient strength for stair climbing, to use this example again, is by no means evidence that stair climbing is being done. In one instance a young adult had accepted the fact that he must be house-bound because he could not step up on a curbing. Actually half an hour's practice under direction was all he needed. In another, a child was crawling on hands and knees up four floors when stair climbing with the installed railing was quite possible.

Not every person tested will show need for training, nor will each one show gain which can be recognized since the test is gross in its application and not detailed. Testing functional ability is well worth the time spent, as a surprising amount of helpful information, both to tester and performer, usually results. There is also the satisfaction of knowing that nothing has been left undone. If teaching help or some other need is demonstrated, it becomes the duty of the physical therapist to do something about it. For example, a problem of muscle training, aside from

its use in a skill, may be present; or a question of referral to the doctor for a check on apparatus (braces, crutches, shoes); or, very frequently, just a matter of providing opportunity for practice under direction.

Second, the test is of interest to the patient as an objective measurement of his own improvement.

Unless we are careful, we in orthopedic work sometimes find ourselves working *on* the patient rather than *with* him! The giving and evaluating of an activity test does a great deal to change this situation, if it exists. It enlists the patient's cooperation and interest since it tests him in things which he wants very much to be able to do. It may also record slight but precious gains such as the ability to walk a few feet farther. In regard to possible gain, it is encouraging to note that with the two largest groups of special school pupils, children with cerebral palsy and poliomyelitis, practically every child will show some gain unless already adequate in activity *when his orthopedic program has been properly administered.*

Orthopedic improvement is of necessity a long drawn out process. If the patient can from time to time see some gain, he is more appreciative of the therapeutic and other efforts such as surgery, being made in his behalf; and he becomes a more willing partner in the enterprise.

Third, the test predetermines individual activity fitness for a new situation.

In the case of a special school pupil the test will show if he is ready for a regular school (where such activities as hand usage, self care, distances, speed in walking, and stair climbing are required); if he can be sent to a camp at the beach or in the mountains; or even if he can take a trip downtown for shopping without special provision of any kind.

It is almost impossible for the average able-bodied person, even though he is a physical therapist, to foresee the social-emotional as well as the physical "hazards" and embarrassments which await the crippled individual when he leaves his relatively protected home or school situation. Seeing is believing, and a few short trips with a crippled child on the subway or shopping will make a convert to functional training of almost any orthopedic worker.

We cannot, of course, go with this child to camp or take him everywhere he should go, but we can at least get some idea of his adequacy in a new situation before we send him into it. In some instances we can purposefully train him for the activity demands of a specific situation so that he may enter upon it with every confidence.

Fourth, such a test supplies cumulative data on standards and methods of orthopedic care.

It is only roughly accurate since it records minimum or moderate rather than extreme performance. Even so, it is an actual record of what a person of given orthopedic type does do under observed conditions.

The whole field of orthopedic care is prone to successive waves of enthusiasm and stubborn resistance to new or different therapeutic methods. This is a compliment really to the integrity of the workers who want the best for their patients but it sometimes stands in the way of retention of the best aspects of old methods and acceptance of values in the new.

For example, a careless therapist might give this test to a number of crippled children and learn nothing from it, either as to what may be done to improve the performer's activity or what may be done to improve the therapist's own techniques. It is doubtful, however, because if this test is used at all, it begins to "tell on" the worker who has neglected to teach fast walking, or to report an outgrown brace to the doctor in charge. It pictures the work accomplished and the patient's needs.

It is not hard to see what gains to the patient might be realized, if objective tests were more widely used. We could also have something to aim at in our standards of activity for a patient of given type. All of us at one time or another have an exceptional patient who performs better than the others. Allowing for personal differences in tempera-

ESSENTIAL ACTIVITY TEST
FOR ORTHOPEDIC USE

Name Billy

Birth date 5 11-35

Diagnosis Cerebral Palsy (spastic)

Date of onset Birth

Involvement { Arms / Trunk / Legs } both

	Date 3-20-42 Mark	Comment	Date 6-8-43 Mark	Comment	Date 4-17-44 Mark	Comment	Date Mark	Comment
APPARATUS								
Crutches, braces, etc.		None		Twisters		Twisters		
STANDING								
Habitual position	x	wobbly, prefers to lean		same	x	knees bend slightly		
Time	5m.		4½	min.(stepped)	5	min		
Free standing		as above				steadier		
Time								
WALKING								
Level surface	x L	falls often	x	same				
Up hill	x-L		x					
Down hill	x-L		x	L too fast				
Sideways	L	balance poor	x					
Backward	L	flings arms	L					
Rough surface	L	trips	L			same		
Slippery surface	L		L					
Turn	x	large circle	x	same				
Stop under control	x-L		x	L				
Walk without brace:								
Indoor								
Outdoor								
Timing:								
100 ft.	26"		21"		18"	jerks shoulders		
250 ft.	1'26"		1'24"		1'			
500 ft.	2'42"		2'40"		2'			
750 ft.	--	(tired)	3'59"		3'1"			
1000 ft.			5'16"		4'8"			
1250 ft.			6'35"		5'13			
1320 ft.			6'51" +	(could walk farther)	5'30" + +	(not tired)		
Gait (describe)	swings arms out for balance. left foot turns in front of right some lateral trunk swing		steadier slaps right foot		Gait steadier Knees straighter			

MARKING:
N-Normal
X-Adequate to essential needs
L-Limited in speed, balance, endurance
MA-Mechanical aid-wall, railing, chair
PA-Person helping but not carrying
O-Impossible
COMMENT:
Describe ways of doing things if unusual.

BRANCH BROOK SCHOOL, NEWARK, N. J.
ORTHOPEDIC PHYSICAL EDUCATION DEPARTMENT

Figure 1. Front sheet of "Essential Activity Test"

ment and other factors we need to know what makes this patient walk so well and so quickly when another very like him may not do so well. What must we do to help others equal his performance? And what may we consider standard or average for a given skill? And a given type individual?

These are only a few of the questions to which we urgently need the answers. Testing alone will not give them to us but it is one technique in the orthopedic program which helps toward an honest evaluation of the field of orthopedic care. Gain in activity is but one criterion of orthopedic improvement but it is a very important one.

A facsimile of "The Essential Activity Test for Orthopedic Use" and directions accompany this article. There are no restrictions in the use of this test by other workers. Findings relating to the child,

8 Billy

	Date 3-20-42 Mark	Comment	Date 6-8-43 Mark	Comment	Date 4-17-44 Mark	Comment	Date Mark	Comment
GEN. ACTIVITIES								
Stairs:					MA	1'12		
Up	MA	stumbles	MA	touches lightly		still		
Down	MA	48 steps 1'56"	MA	1'43"		awkward		
Chair:								
Sit	X		x		x			
Stand	X		x		x			
Pull up	x		x		x			
Rise from floor	x	5" (slow)	x	1½"	x	2"		
Manage doors	x		x		x			
Bus: In and out	MA	or carry	MA		MA			
Auto: In and out	MA		MA		MA			
Step up on curb	MA	or PA	MA	preferred		same		
Cross street alone		Not allowed		same		same		
Use hands over head	X	sitting L stdg		balance		same		
Pick up from floor	x		x		x			
Telephone								
Carry parcel:								
Indoors	L		L		L			
Travelling	O		O		O			
Write, print, type		train for righthandedness						
Hold a book	N		N		N			
SELF CARE								
Feed self	PA	cut meat	PA	cut meat	N			
Toilet	x		x		N			
Bathe	x	says	x	says	x			
Brush teeth	?	not clean		same	x			
Comb hair	X		x		x			
Dress self	x	ties etc OK	x	slow	x			
GAMES						should lift		
Run 50 feet, Time	7"	L ft turns in	5"		5"	knees		
Use of ball (standing)								
Bounce								
Throw		L						
Catch		balance and attention		x-L	x-L			
Bat								
Pick up								

Figure 2. Reverse side of "Essential Activity Test"

Billy, are entered on the record by way of illustration.

FINDINGS ON BILLY'S TEST

Walking Skills and General Activity. A study of Billy's performance shows him to be poor in balance and stability, both in standing and walking. He is quite awkward and easily upset, especially when changing direction as in going around a corner. His walking appearance is poor due to his use of arms for balance and more swing to the side than is normal. Walking speed is adequate. He is fairly good in stair climbing with a railing but not good enough to go alone in public places.

Hand Usage. Billy's hand usage has considerable interest from a school, teaching, and skill viewpoint. He early gave evidence of being ambidextrous. This was not brought out in the test but would be observable to a careful tester. His teacher reported him for attention in regard to handedness since he used either hand alternately without any noticeable preference. Handedness tests were indecisive. He apparently did not care which hand he used. Eye tests were then given him to determine which was his dominant eye. This showed conclusively that he was right eyed and the recommendation was then made by the eye specialist and orthopedic doctor that he should be trained to be right handed. This has been done in writing, eating and game skills. This indecision in hand usage shows up in Billy's slowness in hand work. He rarely finishes any hand work without prodding. He much prefers to read which

he does well above his grade and age level. Not long ago an observant teacher helping Billy to learn to play "parchesi" at play time reported that, though "smart" enough at the game rules, he was unable to follow the right handed track around the parchesi board but constantly doubled back on his own trail with his men. This led the other players to call him stupid. A check up in his exercise period demonstrated that Billy still was confused as to right and left hand. When a mark was placed on his right hand (from which the play started) he completed the circuit properly.

Self Care is adequate although Billy is no Beau Brummel. His negligence is that of a child with other interests rather than a true deficiency in hand strengths or skills.

Game Skills are rather poor, doubtless attributable to a variety of reasons; among them, the awkwardness in balance and the rather poor hand usage; and a resulting lack of interest in these things which are not done so well. Game interest is intense in some small "one man" gadget such as a gyroscope top. Group games are just beginning to appeal to him and then only with some pushing.

CONSTRUCTIVE USE OF TEST FINDINGS

Billy's test analysis does not lead us to change his present program of orthopedic physical education care in the special school to any extent. What we would like is to give him more of what he is getting, especially the muscle training devoted to strengthening hip abductors and outward rotators since weakness in these muscles is responsible for many of his troubles. His program consists of muscle re-education and strengthening; gait and balance practice three times a week (one-half hour period) supplemented by group rhythm once a week in which smooth graceful patterns of motion are emphasized; and a daily free play period which provides opportunity for hand skills, general activities and social participation with others. Billy is expected to walk as well as he can during the school day. His classroom seat is properly adjusted, and all his teachers understand his problems in relation to his gait and handedness.

In Billy's case, the test originally served as a guide so that we included more balance and skill training in walking in the exercise period. It now verifies the adequacy of the program since gain has been consistent although not remarkable in any way.

DIRECTIONS FOR THE ESSENTIAL ACTIVITY TEST
(For Orthopedic Use)

This test has been developed to supplement the usual muscle test and orthopedic inspection as a basis for planning a practical orthopedic program for the crippled individual. It tests simple everyday activities only and is of most use in those cases where the disability is sufficient to interfere with the individual's personal independence. The functional training which may be suggested by the use of this test should be given in addition to—not in place of—routine orthopedic measures known to be helpful to the individual concerned.

The person to be tested should wear comfortable indoor clothing. He should use his routine orthopedic apparatus unless otherwise noted. This includes braces, lifts, crutches, canes, artificial limbs and use of wheel chair for riding or pushing when necessary.

Caution! **The instructor must be ready to offer aid in any activity with which the performer is unfamiliar or in which unusual speed or balance is required. Stand in back of him as he goes up stairs, in front of him when he comes down. Stay near him and if necessary hold him loosely by a belt or shoulder strap the first time he attempts to work fast or run. Be** sure he is protected from sharp edges, as of a nearby table, when he bends over.

Any individual who is restricted in activity for any reason (heart, recent operations, fragile bone conditions) should be given only such parts of the test as are perfectly safe for him.

MARKING

The following symbols are suggested for use in the small left hand column. Use the rest of the line to describe briefly positions, gaits, ways of doing things when they are unusual.

Activity Possible:
Without aid

- N. Normal or average in all respects
- X. Adequate to minimum needs but not normal
- L. Limited—slow, weak or unsteady

With aid

- MA. Mechanical aid—support needed from nearby table, chair, wall or railing
- PA. Personal aid—someone else helping but not carrying

PP. Person present, ready to help if necessary
Activity Impossible: O
Activity Never Tried: To be listed

The test should be given in the form of a demonstration of each activity when possible combined with a rather detailed questionnaire. Questions suggested are examples only. Use others if they seem to apply better to a particular situation.

Not every heading in the test is discussed here, those which seem to be self-descriptive being omitted.

QUESTIONS AND SUGGESTIONS

APPARATUS. Describe and say if used part time only. Note fit and comfort.

Q: Do you wear your braces all day or take them off when you get home?

Q: Do you use a cane when you walk in a crowd?

Q: Can you walk indoors without your cane?

STANDING. Habitual means ordinary uncorrected position. Note weight bearing, instability and fatigue symptoms.

X means ability to stand 5 minutes.

Q: Please stand the way you like to until I ask you to sit down. Do not touch anything near you or move your feet if you can help it. (Free standing means without crutches or cane.)

Q: Will you show me how you stand without using your crutches?

X—5 min.

WALKING. Level surface usual indoor or smooth sidewalk surface.

X: Adequate to home and school needs.

Q: Are there places where you can't go because of your walking? To the store? Downtown?

Q: If you go somewhere with your mother (sister, friend) do you get tired before she does?

Q: Have you fallen down today? Yesterday? Why? (Stumble, slip, knee give way?)

Uphill-Downhill

X: 15 per cent grade 25 feet more or less.

Q: Do you go alone up and down hill?

Q: Do you go backward up a steep grade?

Q: Please show me on the ramp.

Sideways-Backward

X: 25 feet.

Q: Can you step sideways so as to get into a seat at the movies? In church? Will you show me? Please step to the right (left) until I ask you to stop.

Q: Can you step backward so as to open a door toward you? Will you show me how you walk backward? Don't stop until I say "stop."

Caution to instructor: Be sure to stand in back first time child is tested.

Rough surface—Grass, sand, uneven sidewalk, deep snow.

Q: Can you walk in the park? In the woods? At the beach? Over rough sidewalk?

Slippery surface—Waxed floors, wet street, ice.

Q: Do you have to stay in on a slippery day?

Q: Can you walk on rugs on a waxed floor?

Turn—From a fast walk if possible.

Q: Sometimes you need to turn sharply or stop at once when crossing the street in traffic. Will you show me how you do this? Walk in any direction you like until I say "Turn!"

Stop under control—from a fast walk.

Q: Please stop at once when I ask you. Walk fast, please.

Walk without brace. Emergency need only.

Q: Can you get to the bathroom alone after your braces are taken off for the night? How?

Q: Can you get around with crutches if your brace is broken?

Timing. Purpose—to give a record of fast walking for a short distance, 100 feet, and ability to walk a longer distance (up to 1,320 feet) at ordinary walking gait.

100 feet. Q: I want to see how fast you can walk for a short distance. Walk any way you like. (Distance should be plainly marked) 250 feet and up: Q: This is to see how far you can walk without resting. Do not hurry. Walk as if you were going to your room, to the store. If you get tired before I stop you tell me and you may stop earlier. *Note:* In marking endurance walking a plus (+) will indicate that the individual could easily walk farther, a minus (—) that he is tired.

GENERAL ACTIVITIES

Stairs. Take timing for about 25 steps up and 25 steps down if possible.

Q: I want to see how well you can climb stairs. Go up (and down) until I ask you to stop. Hold on if you need to.

Q: Do you live upstairs? Does anyone else help you to go up (come down)?

Use Hands Over Head. Q: Can you reach up

to turn on a light? Get a dish out of the cupboard? Must you lean against something to do this? Will you show me?

SELF CARE

Feed Self. Q: Can you cut meat? Butter bread? Hold a glass of milk? (Real eating should be observed)

Dress Self. Q: Can you undress alone? Dress without help? Will you tie your shoes? Unbutton your coat? Put on your sweater?

GAMES

Run 50 feet. Q: I would like to see you run. Run any way you like. *Note:* Take timing for 50 feet if the child is permitted to run. (Some bone cases are not). Observe and describe preferred gait which may be quite unusual.

Dodge. Q: Do you play dodge ball? Tag?

Use of the ball. Q: I want to see how you play with a ball. Will you catch this? Throw it to me? Pick it up? Bat it? Bounce it? Q: Do you sit down to bat or throw when you play baseball?

This material is revised from a lecture and demonstration given at the Conference on Orthopedic Nursing, October 2, 1944, New York City.

A Parable for Nurses

By MARION GARLAND, R.N.

"The common problem, yours, mine, every-one's,
Is, not to fancy what were fair in life,
Provided it could be,—but finding first,
What may be, then find how to make it fair
Up to our means."

MARY SMITH and Ann Harris had always been friends. They grew up together, as the saying goes, and together they had chosen public health nursing for their profession. They were bright, intelligent young women with similar backgrounds, eager to give their best to their chosen work.

On this particular morning we find them ready to start out on their rounds for the day. At the corner they waved each other good-by, and with "I'll see you at lunch," went their separate ways.

Let us go along with Mary Smith as she made her rounds.

Mrs. Barnes and her eight-day-old son were waiting for her. In a trained and capable manner she proceeded to give the necessary bedside care. As she bathed and dressed little Jimmy, she told the young mother the "do's and don'ts" of infant care. Mrs. Barnes watched with interest and an occasional question.

As she finished, the nurse said, "And now Mrs. Barnes, you *must* do these things every day to keep little Jimmy well and healthy."

Then something happened. That little word "must" struck a discordant note in the young mother.

The nurse sensed something was wrong even before Mrs. Barnes replied, "Well, all this fuss may be all right but my mother had twelve children. We all grew up well and healthy with never a sick day and I can tell you we weren't brought up by any such rules."

Poor Miss Smith! The day that had started so happily turned cold and gloomy before the first visit ended. As she left the house she said to herself, "What an impossible person Mrs. Barnes is! How can anyone teach a person like that anything, and she seemed so interested at first."

The next call took her to the third floor of a dark tenement house. The hall was dirty and stuffy and she left the door open to allow a bit of fresh air creep in.

As she climbed the stairs she hoped she would find little Joan in bed. She had tried so hard to make Joan's mother

realize that complete bed rest was the proper treatment for a child with rheumatic fever. As she tapped on the door she heard little bare feet hurry across the room.

"Oh, Mrs. Begin, Joan has been up again and you know I told you she was not to get out of bed!"

Both Joan and Mrs. Begin looked guilty and sullen.

"It was just for a minute, nursie," the child pleaded.

"A minute is one minute too much," replied the nurse, thoroughly hurt that the family had again disobeyed orders.

Her heavy heart did not interfere with the efficiency with which she worked but she went about it in silence.

As the bath and rub ended, little Joan said, "You make me feel awful comfortable, Miss Smith." The nurse's heart warmed as she said, "Thank you, Joan. Now remember you *must* stay in bed."

Her next assignment took her outside the city limits to a squalid little house. Mr. Hebert had just returned from the hospital with a draining incision.

The room into which the nurse stepped was cluttered but clean. The one bright spot was the red geraniums blooming in profusion in their tin cans on the window sill.

In her finest professional manner, the nurse did the dressing and told the family she would return the following day.

When the door closed behind her Mrs. Hebert remarked, "She's efficient all right—all business though. Why, I don't think she even saw our posies!"

As Miss Smith waited for the bus she thought, "Those red geraniums were the one bright spot in that house. I am glad there was something nice there."

Just time to fix up Grammy Woods before lunch—poor dear! She had been in bed weeks upon weeks with a broken hip. She and Grammy understood each other. She reminded the nurse of her own grandmother.

As she entered the house, the kind old voice called, "Hello my dear, you are late this morning."

From anyone but Grammy the nurse would have resented being told she was late, but now she replied, "Oh, it is so good to get here! Everybody has been impossible today."

Then followed a happy half hour—the one satisfactory experience of the morning. While she worked she and Grammy chatted.

As she was leaving the daughter of the old lady shyly offered the nurse a mince turnover. Almost on the point of refusing, something prompted her to say, "For me? How nice of you!"

With a gay "Good-by" to Grammy she left, wondering why things were so different here and why the other calls had been so difficult. She and Ann would talk it over tonight but somehow Ann always got the best families and they always did what Ann told them.

Ann Harris, too, had had a busy morning. She hummed to herself as she ran up the steps of the O'Neil house. Tommy would be waiting to have his poor crippled leg dressed. Dr. Jones hoped this last operation would make it almost straight.

As she opened the door Tommy shouted a joyous, "Hello, nurse!" But Mrs. O'Neil said anxiously, "I hope everything is all right. It is awfully hard to keep him quiet, now he is feeling better. If only his father were here to help me."

The nurse smiled at Tommy as she said, "But you do try to be a good soldier and obey orders like your Daddy, don't you, Sergeant O'Neil."

While she worked she told Mrs. O'Neil and Tommy about the home teacher the Department of Education provided for boys like him who had to be absent from school over long periods.

"Gee!" said the ten-year-old. "I'm not crazy about school but I hate to have the other guys get ahead of me. Will she be nice like you, Miss Harris?"

The nurse assured him the teacher would probably be nicer than she, and with a smiling good-by she left both Tommy and his mother happier because of her visit.

Next came the Page's. Mr. Page had recently returned to his wife and four-

year-old son from the war area, shattered mentally and physically. The adjustment to civilian life had been difficult.

On her previous visit the nurse had found the family depressed and miserable. The joy of reunion had worn off. Mr. Page was unable to return to his old job. The noise and confusion caused by his young son, whom he scarcely knew, annoyed him; and, to Mrs. Page, her husband seemed a different person than the care-free man who had left her three years ago.

It was then the nurse had suggested that Miss Plummer come in. Of course she didn't use the word handicapped but she told him this person would help him find something with which to occupy himself until he could go back to his old work.

She also told Mrs. Page about the nearby nursery school where she could place Junior.

What a different picture greeted her as she entered the house today. The Pages actually looked happy! Mr. Page was doing leather work left him by Miss Plummer. "Always liked the feel of leather," he said. "And I am going to be paid for what I do, too."

"And Junior loves nursery school," Mrs. Page reported. "And with more time to ourselves John and I are beginning to know each other again."

The nurse feared the next call wasn't going to be easy. Mrs. Hobbs had been so upset when it was discovered, upon his examination for service, that her husband had tuberculosis and had to go to the sanatorium. Of course it was imperative that she and the five children be checked.

Well, perhaps Mrs. Hobbs would understand. She surely had followed instructions about the disinfection of the room after her husband's departure.

Mrs. Hobbs looked weary and forlorn as she opened the door.

She greeted the nurse with "Oh! it's you. I hope this doesn't mean more trouble."

Miss Harris gave her her brightest smile before replying, "I hope I don't mean trouble to you or anyone else, Mrs. Hobbs. First of all I phoned Dr. Kerr this morning. He says Mr. Hobbs is doing exceptionally well, and while it will take some time, he feels you may expect a complete recovery for your husband."

Through her tears Mrs. Hobbs sobbed, "Oh, Miss Harris, I am so glad. I'll do anything you want me to now."

And so the call wasn't difficult at all, and when the nurse left, arrangements had been made for the family to be ready when a member of the Red Cross Motor Corps would call and take them to the tuberculosis clinic for chest x-rays.

The nurse said as she was leaving, "Oh, by the way, didn't you enjoy Miss MacDonald from the Department of Public Welfare, who came about Mr. Hobbs' expenses at the sanatorium? It is going to help him, too, to know you are to have 'aid for dependent children'."

Just time for one more call before lunch. The Kelly's were the nearest so she would go there.

My! how cold it had grown, and how bleak the house looked.

She rapped and opened the door on a fireless, cheerless room. Huddled together on an untidy bed were a young mother and two small children.

To her dismay, the nurse found very little wood and less food in the house. Quickly she built a fire and made warm cereal, and then succeeded in getting their story.

Yes, Mrs. Kelly's cold was better, but with practically no food or very little fuel in the house, she had decided she and the little girls had better stay in bed. Anyway she was too discouraged to get up. It had been several weeks since she had heard from her husband and her government check had not come through.

As she listened the nurse had quietly dressed the children, tidied up the room, and had a roaring fire going.

She promised the mother she would call Red Cross as soon as she could reach a telephone, and assured her that her financial difficulty and other immediate problems would be straightened out before night.

The warm fire and hot cereal had worked wonders, and when the nurse left, the children were playing happily in front of the stove, and Mrs. Kelly had regained some of her usual confidence.

And so the nurse with the understanding heart hurried away to lunch with her friend.

Paper presented at New Hampshire Conference of Social Welfare, Manchester, New Hampshire, January 1944.

Advanced Programs of Study

ACCORDING to the Annual Report data, submitted in July 1944 by the thirty universities having programs of study in public health nursing approved by the National Organization for Public Health Nursing, *eleven* of the thirty offered, during 1943-1944, advanced programs* of study in public health nursing in one or more of the following areas:

Supervision in Public Health Nursing	8
Org. & Adm. in Public Health Nursing	4
Industrial Nursing	4
School Nursing	3
Orthopedic Nursing	2
Venereal Disease Nursing	2
Tuberculosis Nursing	1
Teaching in Public Health Nursing	1
Pediatric Nursing	1
Maternity Nursing	1
Public Health Nursing Education	1
Health Education	1
Teaching of Home Nursing and Child Care	1

The number of areas in which advanced programs were given, and the number of universities giving them are:

3 universities offer one advanced program
5 universities offer two advanced programs
1 university offers four advanced programs
1 university offers five advanced programs
1 university offers eight advanced programs

Industrial Nursing	15
School Nursing	12
Supv. in Public Health Nursing	8
Org. & Adm. Public Health Nursing	6
Orthopedic Nursing	4
Tuberculosis Nursing	4
Venereal Disease Nursing	2
Maternity Nursing	2
Pediatric Nursing	1
Communicable Disease Nursing	1

The number of areas in which separate courses were given, and the number of universities giving them are:

7 universities offer one separate course
5 universities offer separate courses in two areas
2 universities offer separate courses in three areas
4 universities offer separate courses in four areas
3 universities offer separate courses in five areas

Five of the thirty universities offered no advanced programs of study in public health nursing, and no separate courses in advanced areas.

The Education Committee, working with the specialists in the various fields, is studying the content of some of these programs to determine whether the already established ones are meeting the needs of the nurses in the country as a whole, and, if not, the resources for the development of others. Reports will appear in the magazine, beginning with the one on "Preparation to Meet Psychosomatic Problems" in this issue.

The work of the NLNE Committee on Postgraduate Clinical Courses is closely related to this same problem and public health nursing has been represented on the Committee since its formation in July 1943. Reports of its work, concerned with basic principles, criteria, and so forth, have appeared in the following issues of the *American Journal of Nursing*—June, July and December 1944.

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*Exclusive of and over and above the program of study in public health nursing accredited by the NOPHN. "Advanced" includes preparation for supervision, administration, and so forth, in the general field, and preparation in the special fields (beyond the program of study in public health nursing) for staff nurse, as well as consultant.

The data appears as reported by the 30 universities, and is according to their interpretation of "advanced." While, in general, this coincides with the single-starred footnote, it is not entirely true. This would seem to indicate the need for an agreement—at least, on terminology.

Employment of Japanese-Americans

A SURVEY about the use of Japanese-American nurses in the field of public health made last fall by the National Organization for Public Health Nursing met with varied and interesting responses. Prompted by the efforts of the Committee on Resettlement of Japanese-Americans to plan opportunities for graduate nurses and the young women now in nursing schools, the NOPHN survey brought forth 64 replies from 100 agencies employing 25 nurses or more as to their present employment of Japanese-Americans and future willingness to employ such workers. The replies came from every section of the country. Of the 64 agencies, 12 employed 100 nurses or more; 18 employed 50-99; 34 employed 25-49.

Japanese-American workers were employed in 10 of the agencies replying. In only three were the employees nurses—in a nonofficial agency on the eastern coast and in two health departments in the Middlewest. One health department in the Pacific states did have a Japanese-American nurse on its payroll who is now on an enforced war leave of absence. Six agencies, most of them in the Middlewest, employed Japanese-American clerical workers; one employed a nutritionist.

Eighteen of the 64 agencies seemed willing to consider the employment of Japanese-American nurses, with such comments as, "Will consider any well-qualified applicants" and "Would fill position with Japanese-American if her qualifications were good, if workers were not brought in contact with clients." One health department in the mountain states reported it hoped to use Japanese-American nurses in local programs, could not place them on the state payroll. A midwest health department replying in the affirmative stated, however, "Using a Japanese-American nurse would create another hazard in relationships." Most of the affirmative replies stipulated the necessity of meeting the required qualifications. A number of the health departments and boards of education mentioned that all workers must qualify under Civil Service examinations open to all citizens.

Twenty of the 64 said they would be willing to consider the employment of clerical workers of this nationality.

Comments of the agencies unwilling to consider employment of Japanese-Americans in either nursing or clerical positions were enlightening. Some revealed a fear of introducing an additional race problem in areas with Negro or Latin American populations. A southeastern health department stated it briefly, "We have race problems of our own." A southwestern health department said, "We do not feel it would work satisfactorily due to the high percentage of Latin-American population." Several agencies reflected the high war feeling in such statements as: "Many of our employees have now or did have relatives in the armed services, fighting the Japanese, and are not yet able to accept the Japanese-Americans as equals and associates; this would also apply to our public," from a midwest health department. "I feel that it would not be advisable at the present stage of the war to employ Japanese-Americans in our rural areas," from a state health department in New England. The Pacific states agencies indicated, of course, that present army regulations preclude acceptance of Japanese-American employees. A board of education wrote, "Prior to Pearl Harbor our examinations were open to all American citizens regardless of their racial extraction. How soon we shall return to this policy will be a matter for us to consider when the Japanese-Americans are returned to this area."

Rural areas seemed less inclined to feel it possible to employ Japanese-American personnel "who will meet the public." For example: "While we have no prejudice against Japanese-Americans, there are none in this area, and therefore we do not believe nurses would be happy here," from a New England state health department. "Because of the conspicuousness of any public health nurse in rural areas, we believe we would be

doing no kindness by exposing so obvious a 'foreigner' citizenship notwithstanding to the rural psychology," from a southern health department.

Thus the answers indicate some willingness to employ Japanese-Americans in large cities which have no marked racial problems. D.E.W.

PUBLIC HEALTH NURSING STUDIES

Lists of studies in nursing education, made by students in conjunction with work for advanced degrees in the institutions listed, have been prepared by the Association of Collegiate Schools of Nursing (June 1943 and February 1944). Studies of interest to public health nurses include:

"Health Education in Regard to Tuberculosis;" University of Washington. Copy available university library.

"An Analysis of Manuals and Evaluation Records of Three Selected Public Health Nursing Organizations to Determine the Degree to Which Administrators Express an Interest in Professional Attitudes and Personality Attributes as They Affect the Total Nursing Performances of Staff Nurses;" Frances Payne Bolton School of Nursing, Western Reserve University.*

"The Care of the Mother and Baby—One Section of a Textbook on Home Hygiene and Care of the Sick for the Chinese;" Frances Payne Bolton School of Nursing, Western Reserve University.*

"Functions of the Public Health Nurse in the Day-Care Program for Preschool Children of Mothers Employed in Defense Areas;" St. Louis University School of Medicine, St. Louis, Mo. Copy available university library.

"History and Development of the Orthopedic Program in South Carolina, 1918-1940;" Frances Payne Bolton School of Nursing, Western Reserve University.*

"The Philosophical and Historical Setting in Which the Public Health Nursing Administrator Finds Herself;" Frances Payne Bolton School of Nursing, Western Reserve University.*

"A Study of the Available Opportunities of the University of Nebraska School of Nursing for Practical Experience in Public Health Education for Student Nurses Through the Use of Out-Patient Department Facilities and Community Agencies;" Frances Payne Bolton School of Nursing, Western Reserve University.*

"A Survey of the Care and Supervision of 100 Mentally Ill Patients Paroled into the Community from Two State Hospitals in Washington and New Jersey;" University of Washington; copy available university library.

"Syphilis Control Program in Industry;" St. Louis University School of Nursing. Copy available university library.

"An Activity Analysis of Orthopedic Nursing;" Teachers College, Columbia University.

"An Analysis of the Introductory Program for New Staff Nurses in a Visiting Nurse Service;" Teachers College, Columbia University.

"An Annotated Bibliography of Lay Participation for the Use of the Rural Public Health Nurse Working in an Official Agency;" Teachers College, Columbia University.

"An Appraisal of Ten Interviews Held by Five Experienced Supervisors and Five Senior Advisers in Public Health Nursing in a Given Organization;" Teachers College, Columbia University.

"The Development of a Plan for Evaluating the Health Services for Children in Nursery Schools and Day Nurseries of New York City;" Teachers College, Columbia University.

"An Evaluation of the Educational Experience of Students in the Out-Patient Department of an Obstetric Hospital;" Teachers College, Columbia University.

"Helping the Student Nurse to Discover the Community;" Teachers College, Columbia University.

"How May the Effective Public Health Nurse Be Described;" Teachers College, Columbia University.

"Nursing Care in Hospitals and Public Health Nursing;" Teachers College, Columbia University.

"A Plan for Field Experience of Teachers College Students of Public Health Nursing in an Official Agency;" Teachers College, Columbia University.

"The Service Load of Staff Nurses in an Official Public Health Agency;" Teachers College, Columbia University.

"A Study of Teaching Activities as Recorded by Students During Affiliation with a Visiting Nurse Society;" Catholic University of America, School of Nursing Education.

"A Survey of Courses in Supervision in Colleges and Universities Offering an Approved Program of Study in Public Health Nursing, 1941-1942;" The Catholic University of America, The School of Nursing Education.

* Copies are not available.

NOTES FROM THE NATIONAL ORGANIZATION FOR PUBLIC HEALTH NURSING

SCHOLARSHIP RECIPIENTS

Scholarships available to the NOPHN and the National League of Nursing Education through funds from the National Foundation for Infantile Paralysis have been granted to eleven applicants. These awards are to prepare nurses for orthopedic teaching and supervisory positions in hospitals and public health nursing agencies.

Public health nurses who received awards are:

Mildred J. Allgire, Paw Paw, Michigan—public health nurse, Van Buren County Health Department and W. K. Kellogg Foundation.

Eloise Hyatt, New York, New York—Community Service Society.

Helen F. Libby, Seattle, Washington—public health nurse, Snohomish County Health Department, Everett, Washington.

Zeda D. Loveless, Nashville, Tennessee—Davidson County Health Department.

Anita P. Matthews, Chicago, Illinois—physical therapy technician, Wesley Memorial Hospital. (Formerly orthopedic nurse, Vermont State Department of Health, and Visiting Nurse Association, Peoria, Illinois.)

Dorothy Wilkie, Chicago, Illinois—Visiting Nurse Association.

The Joint Committee on Orthopedic Scholarships of the NOPHN and the NLNE, which administers these awards, decided at its last meeting to give scholarships, which are competitive, to qualified nurses throughout the year as well as at the annual meeting, so applications may be submitted at any time.

NOPHN FIELD SCHEDULE

Staff	*Place and Date*
Hortense Hilbert	Philadelphia, Pennsylvania —February
Jessie L. Stevenson	Philadelphia, Pennsylvania —February 9
Edith Wensley	Hartford, Connecticut — —February 8
Alberta B. Wilson	Philadelphia, Pennsylvania —February 13, 14, 15, 16

In addition to the visits scheduled in the January magazine, Louise L. Cady participated in a tuberculosis institute at Freedmen's Hospital, Washington, D.C., January 23-24; Mary C. Connor attended a meeting of National Council on Red Cross Home Nursing, Washington, D.C., January 29; Mable Grover spent the last three weeks of January in Jacksonville, Florida; Hortense Hilbert spent January 15 and 16 in Washington, D.C., and Ruth Houlton spoke at a meeting of the Public Health Nursing Association, Eastchester, Bronxville, New York, on January 29.

COMMUNITY RELATIONS PROJECT

To assist local community leadership in improving race relations and Negro welfare, the National Urban League has recently launched a Community Relations Project. Financed by the General Education Board, the project is one of the League's efforts to eliminate racial friction from postwar reconversion and redevelopment programs of American industrial centers.

Intensive work will be undertaken in only five cities during the first year of the project, but the program will be continued until at least 30 industrial centers have been benefited.

A number of other national agencies with local contacts in the cities to be studied will be associated with the League as a "cooperative team." The NOPHN is among the agencies on the League's Advisory Committee which represents participating agencies and lay membership.

Supervision and administration of the project will be carried on by Warren M. Banner, Ph.D., director of research and community projects for the League, and William H. Dean, project director.

The League is now searching for some field specialists to carry out provisions of the project. One of the specialists is to be a health worker, (who might very well be a qualified public health nurse), whose duties would be as follows:

To advise local leadership in public and private agencies in carrying out the recommendations framed as a result of the field study.

To advise with and assist agency personnel

and board members with problems in providing service to Negroes.

To point out channels for disseminating data on agency services in the community, and to interpret health agencies to those in need of these services.

To assist in organizing demonstration projects where such are needed, and

To bring the people of the community and the agency services into closer contact with each other.

Applicants for the position of health consultant will be welcome and should address any requests for information to Ruth Fisher, NOPHN, 1790 Broadway, New York 19, N. Y., or directly to Dr. William H. Dean, National Urban League, 1133 Broadway, New York, N. Y.

● Her many friends will be saddened at the news of the death of Gertrude Zurrer in Shelton, Connecticut, January 9, after a long illness. Miss Zurrer was an untiring worker on the NOPHN Publications Committee for many years and a contributor to the Magazine as well. She graduated from the Yale University School of Nursing in 1927. Later she did public health nursing in the New Haven and Bridgeport Visiting Nurse Associations in Connecticut, and the Visiting Nurse Service of New York, and was a part-time instructor in public health at St. John's University, Brooklyn, New York. Readers will recall her article on "Freedom from Want" in the August 1943 issue. Despite her illness Gertrude Zurrer was thrilled by the movement of great social and economic forces and their meaning for nurses. In preparation for this review of the United States, Great Britain, and Canada national health plans she patiently reviewed many heavy volumes.

ARE YOU A 100% AGENCY?

If you are a "100% agency" it signifies that every full-time nurse on your staff is a member of the National Organization for Public Health Nursing. This designation supplants the old "Honor Roll" title carried in previous years. The next listing will appear in the June magazine, so if your organization is not among the 100 percenters below, get the name of your agency into headquarters before May 10 in order that you may receive this recognition of complete staff participation in the work of your national organization.

ALABAMA
Ashland—Clay County Health Department

ARKANSAS
*Hot Springs—Metropolitan Life Insurance Nursing Service of Hot Springs

COLORADO
*Littleton—Arapahoe County Health Department

ILLINOIS
Gillespie—Metropolitan Life Insurance Nursing Service

KENTUCKY
*Henderson—Metropolitan Life Insurance Nursing Service
Newport—Metropolitan Life Insurance Nursing Service

MAINE
*Wilton—South Franklin County Nursing Service

MARYLAND
*Frederick—The Federated Charities

MASSACHUSETTS
*Fitchburg—Visiting Nursing Association of Fitchburg
*New Bedford—Instructive Nursing Association
Worcester—Visiting Nurse Association of Worcester

MICHIGAN
*Saginaw—Visiting Nurse Association of Saginaw

MINNESOTA
Mankato—Minnesota Department of Health, District 2

MISSOURI
*Clayton—St. Louis County Metropolitan Life Insurance Nursing Service
*St. Louis—Municipal Visiting Nurses

NEW MEXICO
*Regina—Lindrith Parish Health Center

NEW YORK
*Hempstead—Metropolitan Eastern Long Island Nursing Service

NORTH DAKOTA
*Bismarck—Bismarck Public Health Nursing Service

OHIO
*Akron—Metropolitan Life Insurance Nursing Service

PENNSYLVANIA
*Pottstown—Pottstown Public Schools

TENNESSEE
Memphis—Metropolitan Life Insurance Co.
*Trenton—Gibson County Department of Public Health

WEST VIRGINIA
*Martinsburg—Metropolitan Life Insurance Nursing Service of Martinsburg

ALASKA
Seldovia—Seldovia Public Health Nursing Service

*A 100% agency for five years or more.

NEWS AND VIEWS

Highlights on Wartime Nursing

CLASSIFICATION OF GRADUATE STUDENTS

The demands of the Armed Forces for graduate nurses are acute at this time. Nurses who are available for commissions in the Army or Navy Nurse Corps, as determined by the Procurement and Assignment Service, War Manpower Commission, should not be accepted for scholarships under federal funds, states Lucile Petry, director, Division of Nurse Education, USPHS, in a recent communication to nurse directors of postgraduate programs.

Procurement and Assignment Service committees may, according to recent directives of the War Manpower Commission, classify as essential a nurse enrolling in postgraduate study under the following conditions:

1. The length of the course is not more than one year, and less if possible.

2. She graduated prior to January 1, 1944, and submits a statement to the local committee from her future employer that she has been accepted for a definite essential position for which she needs further preparation.

3. She has been graduated since January 1, 1944, and is *not eligible* for military service, and submits a statement from her future employer that she has been accepted for a definite essential position for which she needs further preparation. In some few cases, the committee may feel that an essential classification should be given an *eligible* nurse graduated in 1944, because she is already enrolled in a postgraduate program and has accepted a definite essential position.

Local and state committees have the responsibility of classifying graduate nurses prior to their enrollment in postgraduate study. The nurse is to be classified under whose jurisdiction she was last employed or where she completed her basic course, if she has not been employed. Nurses should be classified prior to their enrollment to postgraduate study.

Lucile Petry advised that students now enrolled in advanced programs under federal funds should be requested to procure classifications from their local Procurement and Assignment Service Committees.

CLASSIFICATION OF SENIOR NURSES REVISED

Because of the present demands of the military for nurses procedures for classifying senior student nurses have been revised. Questionnaires must now be sent to each student three months before completion of her course. If she is classified as available for military service she must be so informed at least six weeks before graduation, even though she may not have taken the State Board examination.

P and AS committees have been directed to place in Class I all students who: (1) state they have applied or expect to apply for military service (2) do not give sound reasons for not entering military service (3) do not answer their questionnaires by time of graduation. Local committees are to consult with students who give good reasons for not entering military service and advise them about positions they may apply for in order to replace a nurse who will enter military service. Postgraduate study for senior cadets is not encouraged. These nurses are classified in the same manner as other graduate nurses when they become employed and their essentiality in the position is reviewed.

VOLUNTEER NURSES IN ARMY HOSPITALS

The Army urges that civilian nurses volunteer for service in military hospitals in the United States in their spare time.

Responsibility for making them available has been assigned to Red Cross nurse recruitment committees. These committees will determine the suitability of volunteer nurses and maintain a roster of nurses who may apply for volunteer service.

To qualify as a volunteer nurse in an army hospital an applicant must be: (1) a citizen of the United States (2) a registered professional nurse—if actively engaged in nursing, must be currently registered; if inactive in nursing, must

have evidence of having been registered at some time (3) in good standing in her local community (4) able to give at least four hours of volunteer service each week (5) ineligible and not available for appointment to the Army Nurse Corps.

The director of nursing service, American Red Cross, makes the following suggestions to local committees in relation to the voluntary assistance program:

1. Ascertain from local army hospitals the need for volunteer nurses and make it known to the community.

2. Secure personal data about each applicant and at least one reference if she is not personally known to the committee. Confirmation should be made of her registration and citizenship.

3. Provide the nurse with an identification card—if she is an enrolled Red Cross nurse, her badge and membership card will be sufficient; if not, a card should be provided indicating she has been approved for volunteer service.

4. Plan a schedule for each nurse according to the hours she is available and the special needs of the hospitals. Each nurse should report when unable to keep to her schedule, and a substitute for her should be provided.

5. Keep a record of each nurse and the hours she works.

PROPOSED CHILDREN'S BUREAU PROGRAM

Recommendations especially designed to meet pediatric and obstetric health needs but framed with the idea that the facilities and activities should be integrated with the entire community health program on local, state and federal levels were made in December 1944 by the Advisory Committee on Maternal and Child Health of the Children's Bureau. (Ruth Houlton represents the NOPHN on this Committee.) The recommendations made, particularly those points having a bearing on public health nursing, are summarized briefly as follows:

While the consensus of the Committee was that reduction of maternal and child mortality and morbidity can best be achieved by delivering all women in good hospitals under care of competent physicians, the Committee recognized that there are many areas where the use of public health nurses with good training in advanced maternity nursing or nurse-midwifery may aid greatly in establishing higher levels of obstetric practice. The Committee believed that the Children's Bureau and other health agencies could be of great help to these local areas in furnishing such personnel. It recommended, therefore, that the Children's Bureau give attention to expanded facilities for the postgraduate training of nurses in obstetrics. Appropriate remuneration of personnel according to the extent and quality of service rendered was stated to be a requisite for the maintenance and progressive improvement of maternal care.

Under the subject of child health the Committee stated that there is need for the education and training of a greater number of public health nurses, especially those versed in child health problems; that there should be provided in each community public health nurses in at least a ratio of one to every 2,000 inhabitants, for all public health activities; that the development of training centers for public health nurses especially is urgently needed for rural areas; that there is a need of nurses especially trained in the care of infants and children, particularly emphasizing the care of premature and newly-born infants.

The Committee further emphasized the need for better integration of preventive and curative facilities in both rural and urban communities. In rural areas health centers should be developed at the periphery of a central hospital and administrative center. Well baby clinics and child health conferences must be continued and developed, in conjunction with clinics where adequate facilities for diagnosis and treatment of disease are available so that the same physicians can give continuous care in health and sickness.

To insure the fundamentals for any state health program, the Committee recommended that each state be so divided into districts that it is possible for each district to support a health department consisting of at least a full-time physician with a graduate degree in public health, a sanitary engineer, and a supervising public health nurse.

The Children's Bureau was urged to agree to the request of the American Academy of Pediatrics that the Bureau undertake with the Academy state surveys to determine the need for personnel (including public health and pediatric nursing personnel) and facilities to accomplish the objectives stated by the Committee.

It was further recommended that there should be incorporated in all pediatric courses for nurses and other medical personnel more

adequate emphasis on the mental health of children; that an educational program is needed to teach the public to utilize child health facilities; that the Bureau should develop a unit on school health, which, in cooperation with the Office of Education, would carry out recommendations of the Advisory Committee on Maternal and Child Health relating to the school health program; and that the Committee approves the general principle that scales of remuneration be based entirely on professional preparation and merit without discrimination on other grounds.

From Far and Near

Marriages, Births and Deaths in 1944—The spurt in the marriage rate reached its high point in 1942, but the trend has been rapidly downward in the two years following in the United States as a whole, according to the Metropolitan Life Insurance Company (*Statistical Bulletin*, December 1944.) Our large cities, however, have shown wide variations from this pattern, changes being necessarily related to movements of population related to large industries and concentrations of young men in military training centers. Big increases in marriages have occurred in cities like San Francisco, Oakland and Denver, of the Mountain and Pacific Coast States, but decreases in the Middlewest, East Coast States and New England.

Births continued at a high level in 1944 even though there was a recession from the two preceding years. Total births in 1944 were probably somewhat less than 3,000,000, or about 6 percent below 1943, representing a birth rate of about 22.5 per 1,000 resident population, excluding overseas military personnel and civilians. The decline in births in 1944 was almost country-wide, the only notable exceptions being those areas which have continued to attract population because of their war industries or near-by military installations.

The 1944 general death rate in the United States is estimated at 10.7 per 1,000, or about 2 percent lower than in 1943, according to Metropolitan, which observes that the year's mortality must be regarded as exceptionally favorable inasmuch as it is based on the resident population, which excludes the millions of selected healthy young men in our armed forces overseas. If allowance were made for this, the resident death rate would be at or near an all-time minimum.

The natural increase in 1944 in our population is estimated by the Metropolitan to be 1,400,000 persons, based on births and deaths not only of our population at home but including the men in combat zones. A sharp reduction in births is expected soon due to the absence of a large group of young men abroad. So far no serious epidemic has struck the country.

Making Nutrition Education Effective—How to make nutrition education "take" is a vital problem to nutritionists, who realize that the attitudes and ideas of the people they hope to educate are important and consequently seek ways to use them as a guide to effective education. In a study attempting to answer the questions—in what way can the attitudes toward a new food be used as clues to ways of increasing its acceptability? and do different combinations of appeals differ in their effectiveness?—the Food Habits Committee of the National Research Council selected as the food for study the soybean and its products. As a first step men and women in different parts of the country were asked, "How do you feel about using soybeans as food?" It was discovered that soybeans were not thought of as a particular kind of "food" even by people who had eaten them. However, few real prejudices against soybeans were raised, indicating that the task was to teach people to think of them as a definite kind of "food." Four aspects were detected likely to increase favorable attitudes toward the beans: (1) that scientists had found them to be of high nutritional value (2) that they are grown and processed in *America* (3) that they give good value for one's money and (4) that they can be used in a great variety of ways. These four appeals were stressed in a study made in the six identical cafeterias of the Pentagon Building in Washington, D.C., where some 30,000 government employees work. From the findings it appears that the most effective of four combinations of the appeals used is the one in which no mention was made of nutritional value—emphasis on the nutritional value of a *new* food seems to be different from pointing out the nutritive value of an already accepted food. A person is more likely to avoid trying a new food if it is presented as being a healthful food, for then he expects it not to taste very good. In a thought-provoking article about the study in *Journal of Home Economics*, January 1945, Dr. Patricia Woodward concludes that, "In planning any sort of educational program, one needs to know where the people are in their think-

ing and in what direction one wishes to help them move; otherwise, a great deal of effort may be used in a relatively inefficient way."

Diaper Shortage Survey Made by NOPHN—Seventy-five percent of 155 agencies replying to a questionnaire regarding the diaper shortage sent to 340 agencies throughout the country reported difficulty in securing diapers or diaper material in the families of visiting nurse patients. The situation seems most acute in the Middle West and South with a large proportion of agencies in those areas stressing a critical need. Remarks emphasized that the high price which must be paid for inferior quality necessitates more material for adequate protection. There was also comment on the great scarcity of babies' shirts and underwear.

The government is now considering the shortage of diapers, and a solution of the problem may be near through cooperation of OPA, WPB, the diaper services, and other interested groups.

Hospitalization of Casualties in the U. S.—Those public health nurses who are asked by families why their wounded service men cannot be sent to hospitals near their homes will be interested in the statement of Surgeon General Norman T. Kirk, (*Journal of the American Medical Association,* January 20, 1945). General Kirk recently said that more than 30,000 sick and wounded were brought back to this country in December—an increase of 300 percent over July. The three chief factors guiding the medical department in the choice of the hospital to which a soldier is sent are: 1. Where can the patient get the best treatment for his particular case? 2. What hospitals offering such specialized services have facilities available for additional cases? 3. Which suitable, available hospital is nearest to the soldier's home?

Book on Nursing Contest—Awards totaling $1,500 are being offered in a contest for the three most outstanding manuscripts on nursing subjects submitted before March 15, 1946, the McGraw-Hill Company has announced. First choice will receive $1,000, second choice, $400, and third choice, $100. Object of the company in offering the awards is to emphasize the importance of authorship in conjunction with other nursing pursuits and to reward those who, under the present trying conditions, record their experiences for the benefit of others.

The contest is open to any nurse in any country but persons in other professional fields are encouraged to participate. Manuscripts must be written in English, be publishable in book form as texts or reference works, and contain not less than 50,000 words. For further details, write to the Health Education Department, McGraw-Hill Book Company, Inc., 330 West 42 Street, New York 18, N. Y.

Child Welfare Information Service—For the purpose of disseminating information on federal legislation affecting the health, education, employment and general welfare of children and adolescents, some thirty national organizations have organized the Child Welfare Information Service, Inc., at Washington. The new organization will issue bulletins analyzing all bills introduced into Congress concerned with the protection of children as well as important changes in administrative policies in the federal bureaus. While the Service will take no position for or against any legislation as the groups represented in its membership will not necessarily have the same point of view on legislative and administrative problems, it will fill the need for a central clearing house for information on federal action pertaining to children and youth. It hopes to serve, in addition to interested national organizations, labor unions, local parent-teacher associations, women's clubs, child care and family welfare agencies, and community chests and councils throughout the country. Bernard Locker, former assistant executive director of the Welfare Legislation Information Bureau of the State Charities Aid Association of New York will direct the new Service with offices at 930 F Street, N. W., Washington 4, D.C.

Feeding During Convalescence—"Malnutrition following injury or disease is frequent in both military and civilian medicine, although its significance is not appreciated sufficiently," states the Committee on Convalescence and Rehabilitation of the National Research Council (*War Medicine* (AMA), July 1944). Asserting that body stores cannot always meet nutritional needs safely even for short periods of starvation, the committee goes on to say that maintenance of the best possible nutritional status is an important essential in any program for the convalescent. The general physiologic debility of the body which attends malnutrition is manifested in many ways—moderate to severe loss of weight, a decrease in ability to withstand necessary surgical procedures, an increase in the chances of acquiring infection, inability to tolerate any exceptional exertion, delay in healing of wounds, nutritional edema, loss of protein tissue versus adipose tissue. By focusing attention on the diet at the very onset of illness, the necessity can be avoided of treat-

ing the serious effects of prolonged malnutrition. The report discusses six dietary essentials —water, salt, protein, carbohydrates, fat and vitamins; explains the order of their priority in convalescence; and describes methods of handling feeding problems, including the choice of method, control of lack or loss of appetite, and tube and parenteral feeding.

On Wartime Use of Drugs—A statement on the wartime administration of drugs to students, drawn up in 1944 by the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association, cautions that the prescribing of drugs for the treatment of illness should be left in the hands of those especially trained for this procedure.

With the loss of many physicians to the armed forces and recent minor epidemics of illness, states the Committee, many people have considered the advisability of administering drugs to students and younger members of their own families in the hope of alleviating the crowded schedules of physicians. While these individuals may only have in mind "simple and safe" remedies, their actions obviously involve an attempted diagnosis and choice of treatment. Unwittingly dangerous mistakes may be made. The administration of any active drug, according to the Committee, should remain within the purview of the physician although specially trained individuals such as nurses may in many instances administer drugs on a physician's order and under his supervision. "If a student complains of chills, fever, cough, pain in the chest, nausea or other distressing and warning signs, he should be sent home with instructions to go to bed promptly, remain quiet until these symptoms have disappeared, and be carefully watched by his parents or brothers and sisters. Above all, no drugs should be administered unless they are ordered by the physician or his advice concerning their use has been sought."

The drugs most frequently seized upon by the public, the report states, include laxatives, sedatives, aspirin, "cough" syrups, vitamins, cold vaccines, sulfonamides or "sulfa" drugs, and agents for skin afflictions.

"Laxatives are widely used by the American public. . . . Too many people erroneously believe that the intestines must be evacuated regularly each day or twice a day or poisons will be absorbed into the body. This is not true. While it is desirable from a health standpoint to establish regularity, considerable variations can occur without harmful results. Such variation may follow change in diet, exercise, emotional stress, and other influences." The report points out further that the wisdom of purging the gastro-intestinal tract when colds appear is doubtful; that in the case of abdominal pain due to an inflamed appendix, administration of a harsh agent as a purge may cause a rupture; that the continued use of mineral oil as a food may aid in causing serious vitamin deficiencies because of the hindrance in the absorption of vitamin K and carotene.

"The harm that has followed the careless use of sedatives is probably incalculable. Some of these drugs, especially after prolonged use, cause skin rashes, stomach and intestinal upsets, mental deterioration, and even suicides and accidental deaths."

"Cough" syrups, it is stated, are misunderstood drugs, being credited with curing coughs when actually they only provide some relief from a symptom of a disease. "Too often the cough is doctored instead of the underlying condition and proper medical attention is delayed for several days of home treatment. The danger of such action when the cough is due to pneumonia is obvious."

Regardless of recent publicity, "oral 'cold vaccines' are of no value in the prevention and treatment of the common cold."

Although probably the least offensive drug commonly used by the public, aspirin can nevertheless "cause undesirable effects in those who are hypersensitive to this agent, and its use should be restricted unless otherwise ordered by the physician in those who are seriously ill or who seem sensitive to this agent."

"Vitamins have a useful place in the treatment of vitamin deficiencies," the report continues, "but are not advisable for routine use, as such use is an economic waste. Vitamin preparations should be used only when a vitamin deficiency is diagnosed or when certain dietary restrictions exist. They are not cures for 'that tired feeling,' body aches and pains, and colds."

Sulfanilamide and its derivatives are aptly described as miracle drugs when used properly but because of the toxic reactions they are capable of causing in the body, they should be administered only by physicians, who can treat the reactions effectively as they occur. "The possible dangers include effects on the brain, blood, skin and kidneys. Death following the use of the sulfonamides is not unknown. Another objection to the careless use of a 'sulfa' drug is the possibility of the user becoming resistant to its actions, which means that at a later date when that person is seriously ill and may need this drug desperately, he will not be found responsive to the drug's good effects."

With regard to treatment of skin rashes and

(Continued on page A7)

Reviews and Book Notes

FOSTER HOME CARE FOR MENTAL PATIENTS

By Hester B. Crutcher. 199 pp. The Commonwealth Fund, 41 East 57 Street, New York 22, N. Y. 1944. $2.

This book will especially appeal to public health nurses as the problem of foster care for mental patients is approached from the public health point of view of the patient, family, and community. It will also interest nurses engaged in psychiatric nursing and administrators of mental hospitals considering a foster home care program for their patients. Administrative problems are frankly presented. The section on administration points out the saving to the state in such programs as well as presenting the difficulties to be met and overcome. The statistical data gathered from various states participating in foster home care is convincing. The author discusses in detail the colony as opposed to the district system and states that in her opinion the district system is the most satisfactory for use in many areas of the United States.

In consideration of the patient, the public health nurse will not be surprised to note how frequently the "normal family group" is mentioned as an ideal situation in which patients may develop a "more socialized attitude." The chapter on the selection of patients will be of great interest to the psychiatrist and the administrator. In considering the family and type of community best suited to the care of the mentally ill patient or mental defective, it is unfortunate that the author did not mention the public health nurse as a key person in the community to help in such a program. A public health nurse with sufficient psychiatric experience might well aid the social worker in the problems of supervision, although, as is brought out so well in the book, the amateur cannot hope to successfully aid either the patient or the caretaker. He must be familiar with the patient's history, his family, and the caretaker, as well as experienced in the care of mental patients. The public health nurse caring for the entire family unit in the community will no doubt be called upon to participate in this program. She can also contribute a great deal in preparing the community to participate intelligently in this new phase of care for the mentally ill.

The case histories presented are interesting and give one a new understanding of the therapeutic value of foster home care in carefully selected cases. Throughout the book the author stresses the importance of careful selection of patients and homes, as well as close supervision of both "caretaker" and patient by the psychiatric social worker during the patients' stay in the foster home.

The material covered in this book will be of interest to the public health nurse because it gives a detailed discussion of a new phase of care for the mental patient which will undoubtedly grow after the war.

HARRIETT BRADSHAW
Seattle, Wash.

PSYCHIATRY FOR NURSES

By Louis J. Karnosh, M.D., Edith B. Gage, R.N., and Dorothy Mereness, R.N. 339 pp. The C. V. Mosby Company, St. Louis, 1944. Second edition, revised. $2.75.

In this book's second edition the general approach to the subject, chapter, titles and sequence remain the same as in the 1940 edition. There is additional information on recent advances in psychiatry in about 7 of the 29 chapters. These include the technique of electroencephalography, the Rorschach and other tests used in studying personality, and the present-day implications of psychosomatic medicine.

The nursing care in each type of psychosis is discussed following the presentation according to the classification into reaction types of Adolf Meyer of Johns

Hopkins Hospital, Baltimore. Significant additions to therapy are found in the chapters entitled Affective Reaction Types—Involutional Psychosis, Epilepsy and Psychoses with Epilepsy, and Shock Therapy in Mental Disease. A few selected references for further study conclude each topic presented. Pertinent publications since 1939 have been added to those of the previous edition. A list of questions on each chapter may be used for study, review or examination. The glossary of selected psychiatric terms should prove helpful. The authors state that it was their intention to write an elementary text as an introduction of psychiatry for nurses. As such it should be useful to instructors and student nurses.

THERESA G. MULLER, R.N.
Washington, D.C.

HEALTHFUL LIVING FOR NURSES

By Harold S. Diehl, M.D., and Ruth E. Boynton, M.D., 534 pp. McGraw Hill Book Company, Inc., 330 West 42 Street, New York, 1944. $2.50.

This is purportedly a guide to the nurse in the maintenance of her own health and in building up her knowledge of health factors in general. The book offers considerable factual data, much of it, however, in such general terms that it has little application to the daily living of the nurse. In fact, its scope seems too ambitious. The 23 chapters deal with a great number and variety of health factors. It might serve as a reference handbook for numerous clinical conditions but more scientific texts serve this purpose better. Yet it misses its first objective by broadening its focus and not addressing itself to the nurse as an individual. The chapter on mental health for example gives a few descriptive facts about mental illness but offers nothing toward an understanding of basic personality needs in the day-by-day adjustment to life situations. It is not that the above mentioned chapter and other sections, such as those on immunization, exercise, fatigue, choice of foods and conservation of sight, are not applicable to nurses but that they are applicable to other groups also and are for the most part so presented rather than, as has been stated before, peculiarly applied to the student nurse. The chapter on tuberculosis is perhaps an exception.

The second and laudatory purpose of the book is stated to be that of familiarizing the student nurse with measures essential for the maintenance of group health. This is carried out by brief discussions of numerous and various diseases, conditions and factors entering into community health, but they are discussed as such with little reference to the role of the nurse. This makes this part of the book one of facts and not of function. In consequence certain sections, hazards of pregnancy, anesthesia of labor, and appendix D which is the Report of the Sub-Committee on Communicable Disease Control of the Committee on Research and Standards of the American Public Health Association, seem extraneous in a text entitled *Healthful Living for Nurses*. The end result as this reviewer sees it is a book which fulfills no purpose beyond the one already fulfilled by *Textbook of Healthful Living*, by Dr. Diehl. It is a good text for a general orientation course in personal hygiene and community health but not one necessarily addressed to nurses. The list of questions at the end of each chapter is conducive to thoughtful reading on the part of the student, and the list of references is helpful.

HEDWIG TOELLE, R.N.
New Haven, Conn.

LINCOLN'S DAUGHTERS OF MERCY

By Marjorie Barstow Greenbie 211 pp. G. P. Putnam's Sons, New York, 1944. $3.

This is a detailed account of the first organized efforts of civilian volunteers to help an army during the Civil War. It demonstrates the multitude of services necessary if the men are to fight effectively. Mrs. Greenbie has made extensive use of pertinent source material such as letters and documents, and quotes extensively from them. She succeeds in making her people live and in recreating the atmosphere of the Civil War years. This is accomplished through her own phrasing which is curiously reminiscent of the prose of that time. As historical

background, this book should be interesting to lay and professional people. It is not a story of nursing but of volunteer service.

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SMALL COMMUNITY HOSPITALS

By Henry J. Southmayd and Geddes Smith. 182 pp. The Commonwealth Fund, New York, 1944. $2.

The trend in health work today is toward the construction of a permanent community service—one which offers professional, technical and physical resources for the relief of pain and cure of disease, preventive services, social service, educational service, and research facilities, with the hospital functioning as the service center. Such a community service, provided and maintained by the community, needs to be constructed on a solid foundation and this can be done with proper planning and administration within the center. While small hospitals have continually grown throughout the many rural communities for the purpose of rendering a community service, many limitations have handicapped them and the communities have not benefited to the fullest. These facts have been carefully considered by the authors in presentation of this book. With careful thought to the growing demand for health service and hospital care, they have organized the material as a guide in hospital planning, in establishment of financial policies, in organization and administration, in methods of acquiring improved service and in the development of a truly functional organization of all health services of the community.

Nurses specializing in hospital administration as well as nonprofessional administrators will find many practical suggestions in the book. It also offers good reading for those physicians who need a better understanding of hospital and community problems.

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RECENT PUBLICATIONS AND CURRENT PERIODICALS

MENTAL HYGIENE

PUBLIC HEALTH ASPECTS OF PSYCHOSOMATIC PROBLEMS. By Flanders Dunbar, M.D. *American Journal of Public Health*, American Public Health Association, 1790 Broadway, New York 19, N. Y., February 1945. Pp. 117-122.

One of three papers on Psychosomatic Problems in Today's Health Program presented at the Second Wartime Public Health Conference, American Public Health Association, October 3, 1944, New York City. The other two papers, by Mary C. Connor and Ruth Gilbert, appear in this issue of PUBLIC HEALTH NURSING, (pages 61 and 69).

WHEN HE COMES BACK AND IF HE COMES BACK NERVOUS: TWO TALKS TO FAMILIES OF RETURNING SERVICEMEN—With Guide to Community Resources. By Thomas A. C. Rennie, M.D., and Luther E. Woodward, Ph.D. 1944. 32 pp. 15 cents.

A SELECTED LIST OF BOOKS ON MENTAL HYGIENE AND RELATED SUBJECTS. 21 pp. 1942.

SUPPLEMENT TO LIST OF BOOKS ON MENTAL HYGIENE AND RELATED SUBJECTS. 6 pp. 1944.

PAMPHLETS ON MENTAL HYGIENE. 5 pp. 1944.

These three lists are available free from the National Committee for Mental Hygiene, Inc., 1790 Broadway, New York 19, N. Y.

GENERAL

OCCUPATIONAL THERAPY: ONE MEANS OF REHABILITATION—A SELECTED LIST OF BOOKS AND MAGAZINE ARTICLES ON WHAT IT IS AND HOW IT IS USED. By Emily G. Davis. New York Public Library, New York City, 1944. 19 pp. 10 cents.

A HANDBOOK ON HEALTH FOR FARM FAMILIES. Farm Security Administration Publication No. 129. 16 pp. Free. Write Office of Information, U. S. Department of Agriculture, Washington 25, D.C.

BIBLIOGRAPHY ON PUBLIC MEDICAL SERVICE. Committee on Medical Care of the American Public Welfare Association, 1313 East 60 Street, Chicago 37, Illinois, September 1944. 16 pp. 15 cents.